Clinical Lecture
ON
CASES OF EFFUSION INTO THE PLEURAL CAVITY.

Delivered at St. Mary's Hospital, Jan. 10th, 1882,

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(*Concluded from p. 927.*)

TAKING up again the thread of the lecture given four years since I have said that the recognition of the presence of fluid in the pleural cavity is easy, but I should be sorry if you were thereby led to make the diagnosis hastily; it is easy and certain only on the condition that the examination is careful and complete. Now and then the trocar or aspirator-needle is plunged into solid lung or into thick adhesions. Independently, however, of mistakes of this kind, there are differences in different cases, and all such differences have a meaning. There may be old adhesions holding some part of the lung in contact with the chest wall, or there may be other conditions besides the accumulation of fluid, perhaps giving rise to it, such as malignant disease of the lung and pleura, or aneurism. These complications are often revealed by slight and unobtrusive signs which are yet perfectly conclusive, and they can be recognised only by perfect familiarity with the ordinary indications of fluid and care in applying every method of examination. It is not often that we find effusion into the pleural cavity limited and localised by adhesions, but this was no doubt the case in the patient we examined the other day, who was under Dr. Cheadle's care during my absence in August 1878, with double empyema. A considerable quantity of pus was removed by the aspirator; first from the right side of the chest, and then from the left, the woman recovering and giving birth to a child of which she was pregnant at the time. So far as I know this case is unique. In a patient under my care a short time since a collection of fluid, probably pus, which did not extend higher than the fourth intercostal space on the left side, thrust the heart completely over to the right; it must, therefore, have been bounded superiorly by firm adhesions. It does not, however, come within the scope of this lecture to point out the diagnostic signs of the complications I have mentioned, or even to tell you how it may be inferred that the fluid is purulent instead of serous; but it will not be amiss to mention one or two deviations from the usual physical signs which may be met with. I have told you that when one side of the chest is full of fluid the respiratory murmur is extinguished, but sometimes, and especially in children, we may hear distinct vesicular breath sounds posteriorly near the spine, and for some distance outwards from it, down to the very base of the lung, or anteriorly beyond the edge of the sternum at its upper part, extending, of course, in both situations over the dull area. I have known this to be set down as excluding the possibility of effusion into the pleural cavity, or as at least indicating extensive adhesion of the lung to its walls, and requiring great caution in case of paracentesis. It is really, however, only the exaggerated breathing of the other lung heard through the fluid, a thin and tense mediastinum favouring the transmission of the sound. You need not, therefore, make your puncture further to the side than usual on account of it.

It is stated that cases are occasionally met with in which with fluid in the pleural cavity there is perceptible vocal fremitus. As absence of this vibration is one of the most important distinctions between effusion and consolidation the diagnosis is, under these circumstances, extremely difficult, and must turn mainly on the displacement of the heart. I have met with no examples of this exceptional kind, but I have little doubt that the cause of the fremitus is a solidified lung together with fluid, and that the cases are somewhat like those now under observation.

I may remind you again of a case we had in the Victoria ward early in the year, in which we had an unusual condition and perplexing sign. The patient was a girl aged nineteen, a domestic servant, who had been ill for two months, suffering from pain in the cardiac region, palpitation of the heart, shortness of breath, great weakness, &c., which had come on very suddenly. On admission she was suffering from the most extreme dyspnœa; her face was blue; she could scarcely speak; the respiration was hurried and shallow; the pulse weak, frequent, and irregular; the temperature 100°. The entire left chest was found on examination to be almost motionless, dull on percussion front and back; no breath sounds could be heard over any part of it, and there was no vocal vibration. So far we had the signs of distension of the pleural cavity by fluid. It was of course expected that the heart would be pushed to the right of the sternum, and pulsation was felt almost to the right nipple, which had near the nipple the character of the apex beat. There was pulsation, however, also, at the usual situation of the apex—i.e., in the left fifth space, and from this point it was felt all along the last costal cartilage to the xiphoid. The heart sounds were normal to the right of the sternum, while in the cardiac region proper they were distant and had a tick-tack character. It was concluded therefore that the heart was actually displaced, but how was the pulsation in the situation from which it had been dislodged to be accounted for? In the back another perplexing pulsation presented itself; this was along the tenth intercostal space from near the spine to beyond the angle of the rib, and it could be felt as well as seen. All over the left side of the chest posteriorly the heart sounds could be heard and nothing else. These points were made out with great difficulty in consequence of the distress occasioned by the least movement; the only position the poor girl could endure was lying semi-prone on her left side. She was admitted on January 4th, and lived only to the morning of the 6th. The diagnosis was: fluid in the left pleural cavity, displacing the heart; but it was supposed that the pulsation in the cardiac region and in the left back was due either to an aneurism or to a malignant tumour, probably the latter, since it was difficult to imagine an aneurism in this situation large enough to be felt on both aspects of the chest. It turned out on post-mortem examination that with effusion filling the left pleural cavity there was close and universal adhesion of the pericardium to the heart with great hypertrophy, and it must have been the drag of the pericardium so attached by adhesions to the chest wall and to the central tendon of the diaphragm which simulated pulsation.

We may now consider the general question, When should effusion into the pleural cavity be withdrawn? You have seen my practice, and according to my experience the operation is attended with so little danger or pain, and gives so much relief, it so often shortens the illness and makes the recovery more perfect, that the question should rather be, When ought it not to be withdrawn? It is true that it has occasionally shortened life, and I have met with one case, which I have reported to the Clinical Society, in which paracentesis was followed by sudden death. The patient was an elderly man, whose left chest was full of fluid; he dreaded the operation, but submitted to it and bore it well. It took place during my visit to the wards about 2 o'clock; he was relieved, and when seen an hour later was quite cheerful and comfortable; at tea-time he sat up in bed and ate a hearty meal, and shortly afterwards was found to be dead. Apparently the cause of death here was a weak and fatty heart; in other cases thrombi have formed in the pulmonary veins of the compressed lung, and being dislodged by its expansion have passed on into the left auricle and ventricle, and so caused death. Against cases of this kind, which are rare and exceptional, and which would mostly terminate fatally in any case, must be set the far more numerous instances in which removal of the fluid saves life, or in which the neglect of it proves fatal, as I have seen in several striking examples. The rules by which I am guided are as follows. In the absence of urgent symptoms I do not interfere till the chest is full of fluid—i.e., till the dulness is universal over the affected side, with evident displacement of the mediastinum; and when this condition has been reached, or when it is found to exist, as in the case first coming under observation, I usually wait a few days, in some cases ten days or a fortnight, unless the fluid is still on the increase, in order to afford an opportunity for absorption. I delay longer when from the presence of tubular sounds over the entire half of the chest, I conclude that the lung is consolidated; because, as I have explained to you, there is less fluid to be removed, and because it is usually quickly absorbed. The two cases I have related are, in fact, the only instances of

the kind in which I have had to order paracentesis. When there are urgent symptoms, such as dyspnœa, either constant, or induced by very slight exertion, or coming on in paroxysms without assignable cause, there should be no delay in withdrawing the fluid. We should not wait, even if the pleural cavity is not full. Sometimes the fluid is limited by adhesions, and the upper part of the chest on the affected side may be resonant, while at the same time the heart and mediastinum are displaced, and the heart is greatly impeded by pressure. Or there may be disease of the heart, and the fluid, though not in such quantity as to be of itself a source of danger, or even of inconvenience, may add fatally to the heart's difficulties. In kidney disease, again, it may be necessary—or, any rate, very useful—to tap the chest before it is full. Dyspnœa constitutes an emergency which overrides nearly all other considerations. Bronchitis or congestion of the opposite lung, again, must be held to constitute an urgent symptom, calling for removal of the fluid earlier than might otherwise have been deemed necessary, especially when there is violent cough with viscid and blood-streaked expectoration. It was the condition of the other lung which compelled us to interfere in the cases we have been considering. I recommend tapping early when the patient is phthisical, unless it is the affected lung which is compressed by the fluid. There is some reason to believe that compression for a length of time checks, if it does not arrest, disease in the lung; and I may remind you, although it is not a parallel case, that in acute tuberculosis if one lung is compressed by fluid it escapes. I recommend early tapping, again, in old people. There is less elasticity in the structures; the mediastinum does not yield so well as in younger patients, so that the heart is more liable to pressure; while of course it is weaker, and probably to some extent affected by degeneration. The old do not, moreover, bear prolonged illness. In a man at the age of seventy-three, admitted on September 24th, five pints of fluid were removed by aspiration on October 6th, and on the 17th, only eleven days afterwards, he left the hospital apparently quite well. On the other hand, in children it is better to wait for a short time. If the case is not one of empyema, the fluid will probably be absorbed.

I have finally a few words to add as to the operation for withdrawing the fluid from the chest. There are three methods in common use—the old trocar and cannula, with antiseptic precautions, the siphon-acting tube, and the aspirator. After trying them all I prefer, on the whole, and most frequently employ, the bottle aspirator. The trocar and cannula have the advantages of simplicity and expedition, with, I think, a minimum of inconvenience to the patient. Air being allowed to enter freely, the fluid runs out without suction of any kind, and there is no pain from traction on the lung or spasmodic cough such as this traction often excites. When the skin and instruments are surgically clean and the spray is playing on the part, the air drawn into the pleural cavity does no harm, the serum does not become turbid or purulent, there is no rise of temperature, and in most cases the air is absorbed and the lung expands. The only drawback I have met with is that sometimes the air does not undergo absorption, and the artificial pneumothorax or hydro-pneumothorax persists indefinitely. Not long since we had two cases of this kind. In one the chest remained almost exactly as it had been left by the operation for more than a month; the fluid did not increase, and the air was not absorbed, so that we always had the means of demonstrating the amphoric ring or echo and the succussion sound characteristic of hydro-pneumothorax. At length the patient began to have fever and night-sweats, and we had to discharge him with fluid and free air in the left pleural cavity. He presented himself after some time with the lung re-expanded and in contact with the chest wall. In the other the chest had been tapped more than once before the patient's admission by means of an aspirator, but the fluid had reaccumulated. With the common trocar and cannula, air being allowed to enter the chest freely under carbolised spray, a larger amount of fluid escaped than at previous operations, and there was an entire absence of distressing cough or other unpleasant symptoms at the time, and at first it seemed as if the air were being absorbed and the lungs were expanding, but the fluid slowly returned. The tapping was repeated three times with much the same result, though the effusion of the fluid was slower on each occasion, and some little increase in the expansion of the lung was gained. The amphoric sound was not transmitted across the upper part of the chest, and succussion was only audible at last when the patient lay on his back and shook himself. He could hear the splashing himself, and noted any changes in its character with great interest. His temperature never rose, nor was his general health apparently affected at any time; he gained flesh, indeed, and strength, and the only inconvenience from which he suffered was shortness of breath. After each tapping the fluid gradually collected again.

The only fault I have to find with the long tube in which the column of fluid by its weight exerts some suction is that when it is used the removal of the fluid is tedious; and I have in some cases thought that more of it might have been withdrawn with advantage than could be obtained in this way. Dr. Southey's capillary tubes I have only employed once, and did not succeed very well. The aspirator gives us the greatest command over the fluid within the chest. We can withdraw it rapidly or slowly at will. We can arrest the suction instantaneously, and, if necessary, apply it suddenly, with varying degrees of force. The one danger attending its use is the possibility that in inexperienced hands the aspiration may be too forcible or carried too far. I would therefore warn you against this. Nothing is gained by exhausting the bottle or jar too much; it may defeat its own object by causing the tube to collapse, or by provoking prematurely the spasmodic cough which compels us to discontinue our efforts. It must be borne in mind, again, that it is no part of the object of the operation to remove the last drop of fluid; this is as unnecessary as it is impracticable. It is found by experience that when a certain proportion of the effusion is withdrawn, the conditions are so changed that the rest is usually absorbed, and that the absorption is not hastened or return prevented by complete or nearly complete abstraction of the fluid. Gentleness should be our rule and common sense our guide. The spot I have usually selected for the puncture is the seventh or eighth space just outside the line of the angle of the scapula, and beyond the border of the latissimus dorsi. Other situations are recommended as better, and inconveniencies and unfavourable contingencies are described as attending puncture here. I have met with none of these, and accordingly I have so far made no change in my practice. Dr. Powell, on whose opinion I set a high value, prefers the lateral aspect of the chest, and I have sometimes entered the trocar about the mid-axillary line when the patient could not sit up in bed without dyspnœa. The fifth space in the anterior axillary line has, again, been recommended on very high authority. It is safer to make an incision through the skin; this is not necessary if the trocar is really good and the cannula fits well, but a projection of the rim of the cannula, scarcely at all recognisable by the finger, may give rise to extraordinary resistance by the skin which causes the patient great suffering and interferes with the control of the operator over the instrument. The cannula ought to have an eye near the extremity. Instrument makers sometimes excuse the absence of a lateral opening by saying it is a source of weakness, but no force is employed without the trocar in the cannula, and the eye diminishes the liability to blockage by lymph, and prevents obstruction in consequence of the lung or diaphragm being sucked against the end of the tube. Should the flow be arrested prematurely, the aspiration is first to be stopped by turning the tap, and the cannula must then be shifted out of the way of an obstacle or carried in search of the fluid by directing the point downwards into the well formed by the slope of the diaphragm. Sometimes the position of the patient may carry the fluid out of reach, and this may have to be corrected. A flake or string of lymph will rarely block the tube unless it has an attachment to the pleura which prevents it from being carried through, and by the shifting of the cannula it is either withdrawn or broken off. High suction power is never in my experience necessary. Gentleness and common sense will overcome all difficulties. As to the amount to be removed, we have to be guided by circumstances. In all cases the aspiration must be stopped when violent spasmodic cough comes on, and persists in spite of a temporary suspension and a gentle renewal of the withdrawal. When the lung is consolidated, as in the cases related, there is less space for fluid, and a very successful aspiration will give seventy or seventy-five ounces. When the lung has yielded to pressure and re-expands more may be withdrawn, 100 ounces or upwards. If it is known that the effusion has existed for some time, it is prudent to remove it little by little. For example, in a case in which there was a distinct history of dulness over the left chest for six months we drew off forty-eight ounces on the first

aspiration, twenty-four ounces three days later, and eighteen ounces ten days later still, the patient, a young man of twenty-six, recovered perfectly.

I have said nothing about the treatment of effusion into the pleural cavity by any other means than tapping, and this lecture is already too long to allow me to add to it. The subject, besides, is not one which could be disposed of in a few brief sentences. I should have to point out to you that fluid in the chest is not necessarily the result of inflammation, and that you would have to distinguish between simple hydrothorax and pleurisy with effusion, a distinction which would at once involve a difference in treatment. Again, effusion into the pleural cavity may be a secondary effect of heart disease or kidney disease, or of anæmia or other condition of blood, or of cancer or tubercle of the pleura or lung, or of abdominal disease of various kinds. I have said enough to show you how many diseased conditions would have to be considered; and were I to attempt this I should only distract your attention from the interesting diagnostic point which I have endeavoured to lay before you, and the important corollary as to the resort to paracentesis which has appeared to me to follow from it.

Clinical Lecture
ON A
CASE OF INFANTILE PARALYSIS.

Delivered at St. George's Hospital,

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GENTLEMEN,—The case to which I wish to draw your attention to-day is one which well illustrates the results of the disease usually called "infantile paralysis," and is also an example of the kind of treatment to which such cases should be submitted. The disease from which this child has suffered is one which naturally falls under the care of the physician, and I shall therefore give you only a very brief outline of its nature. What we, as surgeons, have to do with is the condition of the limbs left after the disease has come to an end, and it is of this aspect of the case that I wish chiefly to speak to you.

The patient, Annie B——, is a little girl twelve years of age, who, you will have observed, is affected with partial paralysis of the right upper and lower limbs. The history of the case, so far as it can be ascertained, is that at some time during the second year of her age she was noticed to have suddenly lost the use of her right limbs. She does not appear to have been otherwise ill, but, her mother being dead, we have not been able to obtain any minute details of this period. Gradually, however, she regained the power of moving her arms and leg, though not to the same extent as those of the left side; and she tells us that, as long as she can remember, she has been in much the same condition as she is now, and that she is not making any improvement. The following is a description of her condition on admission. She is an intelligent and healthy child, though rather small for her age. The limbs of the *left* side are well nourished and of full activity. The whole of the muscles of the *right* upper extremity are wasted, flabby, and weak. The skin is cold and of a bluish-purple colour. The nails are scaly and ill-developed; the hand and fingers are slightly flexed, and she cannot completely straighten them. She is unable to raise the arm to a right angle with the trunk. There is very feeble grasping power with the hand, and she uses the fingers awkwardly. The lower extremity of the same side is in an almost exactly similar condition, excepting that the wasting is more marked in the muscles of the leg than in those of the thigh; the limb is cold and blue; it is much less in circumference and a third of an inch shorter than the left; there is slight inversion of the foot. She walks with difficulty, and is especially apt to trip owing to her imperfect power of raising the heel; and the instability of the limb is increased by the looseness of the joints, which have lost some of their muscular support. The electrical contractility of the muscles of the affected limbs is diminished, but sensation is normal. There is slight lateral curvature of the spine, the pelvis being tilted downwards to the right side to compensate for the deficient length of the limb.

This case exhibits most of the conditions commonly met with as the result of infantile paralysis, although the muscular wasting and distortion are less than in many of the cases with which we have to deal.

The disease, as its name implies, is one of childhood; it may occur at any time between birth and puberty, the most common period for the attack being during the first dentition. You will remember that the first teeth should be cut about the beginning of the seventh month, and that the eruption of the temporary teeth is going on actively during the whole of the second year. Now this period of infancy, from the seventh to the twenty-fourth month, is that during which children are most prone to the attack of this form of paralysis. The nervous system of children, always very impressionable, is especially liable to disturbance at this time, for besides that dentition and the accompanying changes in the digestive apparatus are actively progressing, the nervous system itself is undergoing rapid growth and development. For this reason especial care should be taken to protect the child from undue nervous excitement and shock, for although the causes of this disease are obscure, the paralysis has sometimes seemed to follow upon sudden changes of temperature, the difficult eruption of a tooth, or other peripheral irritation. The onset of the disease is often preceded by such slight symptoms that no notice is taken of them. The child is usually somewhat cross and restless, and slightly feverish; it is thus put to bed, and in the morning one or more limbs or groups of muscles are found to be paralysed. There may, however, be sickness or convulsions; and occasionally I have seen the occurrence of the paralysis preceded by extreme pain in the limbs about to be attacked. The disease is not often fatal, but tends to more or less complete recovery; but in many cases, after a certain amount of improvement, the progress towards recovery is arrested, and one limb, one group of muscles, or perhaps a single muscle remains paralysed.

The morbid anatomy of the disease shows it to be connected with changes in that part of the spinal cord whence the paralysed muscles derive their nervous supply. There is a marked diminution in the number and size of the motor ganglion cells of the anterior cornu of the grey matter, and an atrophy of the axis cylinders of the nerve fibres, with increase of the connective tissue in the antero-lateral columns. Moreover, examination of the spinal cord at an early stage of the disease in the more acute cases reveals hæmorrhages and other evidences of inflammation, while in cases of long duration the atrophy and sclerosis may have a much more extensive distribution. The paralysed muscles are soft and flabby, and soon begin to waste and to undergo fatty degeneration; there is no rigidity. The growth and nutrition of the limb are retarded; it becomes smaller and colder than its fellow; the skin often assumes a purple and congested appearance, and is apt to be affected with chilblains; a very slight degree of pressure will cause ulceration, and sores once formed are very difficult to heal. The intellectual capacity of children the subjects of this disease is usually unimpaired.

The diagnosis of the results of infantile paralysis is not difficult; it is chiefly from the wasted muscles and weak limbs produced by joint disease that such cases have to be distinguished. I pointed out to you that the limping gait of this child differs from that accompanying hip disease, in that the limb is thrown forwards in a loose way, in contrast to the stiff and restrained movement of hip disease. Moreover, if the child is placed upon her back, the weak limb can be moved freely in every direction, quite independently of the pelvis, and without pain, whereas in hip disease the pelvis moves upwards, after a very moderate amount of flexion of the thigh. The diminished temperature is also a valuable aid to the diagnosis.

Now the loss of power and the wasting and degeneration of tissues which remain in most cases of infantile paralysis lead to results which frequently bring these cases under the notice of the surgeon; but I have thought it necessary to give you some information concerning the disease which produces these results, as without such knowledge no intelligent treatment of them would be possible. One of the

most important results of such paralysis is that, owing to the disturbance of the muscular equilibrium, the limbs often assume unnatural positions, which become developed into permanent distortions. The opponents of the paralysed muscles having no opposition to their action become gradually shortened, and, their function being in abeyance, they also lose activity. Thus the paralysis of one set of muscles leads indirectly to the disuse and loss of power in others, and a limb may be rendered almost useless by the paralysis of but a few of its more important muscles. In this way arise the majority of the cases of acquired talipes, and many other contractions which seriously interfere with the use of the affected limb. Another common deformity which arises indirectly from this disease is lateral curvature of the spine. It happens that the lower limbs more often suffer than the upper, and a good many children who have suffered from infantile paralysis will be found to have one lower limb shorter than the other, owing to the retardation of growth resulting from the disease. Then, to make up for this loss of length, the pelvis is tilted towards the shorter limb, and the consequence of the obliquity of the pelvis is the development of a lateral curvature of the spine, with its accompanying rotation of the vertebræ and ribs. This is well seen in the case under consideration. Another trouble in these cases is the occurrence of chilblains and indolent ulcers due to the ill-nourishment of the skin. Some of you saw recently under my care a girl of eighteen whose leg I amputated because of the pain and inconvenience caused by the ulceration upon a completely paralysed and long useless limb.

You may have noticed that in that case the skin of the whole leg was of a dark-purple colour, like that of a cutaneous nævus, that the limb was very cold, and that scarcely any muscle could be felt in it. That was an example of a severe case, and one which had been long neglected; and the limb had undergone such complete degeneration and was so great an impediment to the girl, that I felt justified in acceding to her urgent request for amputation. But this is a measure which is very rarely called for, because much can be done by proper treatment in most of these cases.

In speaking now of the treatment of the results of infantile paralysis, let me at the outset impress upon you very strongly that if you wish to do any good to these cases two things are necessary—first, that the paralysed limb must be kept warm; secondly, that it must be used. The first of these two is not very difficult to manage. You saw that, for our little patient, Annie B——, I ordered a large knitted woollen stocking to be worn over the whole limb. This is elastic as well as warm, and must be maintained in position without the use of garters; it should extend to the upper part of the thigh. A similar covering may be used for the upper limb. Then friction, the warm douche, shampooing, and passive exercise must be systematically used. These measures will assist the nutrition and growth of the limb. Secondly, I said the paralysed limb must be used. This at first sight does not seem very feasible. How, you ask, is it possible for a patient to use a paralysed limb? Well, in the first place, it is to be remembered that in a great number of these cases the limb is not completely paralysed; some of the muscles escape, and at least retain some of their power. Every possible aid should be given towards the use of whatever muscular power remains; and if it is impossible for the patient voluntarily to move the limb, it must be moved for him, and thus passively exercised; for by far the most efficient means of developing the power of an enfeebled muscle is its moderate use alternating with its complete rest. In cases of partial paralysis of a limb, it is surprising how many movements can be produced by practice in the vicarious action of muscles the functional activity of which is unimpaired.

It is, of course, important to remedy at the outset any deformity which has occurred, and which is an impediment to the use of a limb. Thus if the foot cannot be placed flat on the ground in consequence of the shortening of the muscles of the calf, the tendo Achillis must be divided, and the natural position of the parts restored, so as to allow the action of the weak muscles at the greatest mechanical advantage. This simple measure is frequently followed, as you have seen in some recent cases, by remarkable improvement in the nutrition and power of the muscles. Any mechanical assistance needed to aid the use of the limb should also be given; but all such as leads to the disuse of the limb should be avoided.

You have seen in this little girl how much the muscles have increased in size and power under the daily kneading, rubbing, and active and passive exercise which has been used. Being an intelligent child, she soon learned from my dresser the mode of exercising the weak muscles; the fingers were greatly improved by the carrying and swinging of a gradually increased weight, by grasping sticks of various sizes, and by playing on a board as an imaginary piano; and the muscles of the leg were brought into action by webbing bands sewn to the shoe, by means of which the foot could be pulled in the required direction. We also had the sole of the right boot increased in thickness to supply the deficient length of the limb, and thus remedied the tilting of the pelvis and the lateral curvature. Under this treatment carried out systematically and perseveringly during several months, our little patient has improved so much that she now walks quite upright, and with a scarcely perceptible limp; the limbs are much warmer, and the skin is of nearly the natural colour; she can grasp firmly as well as pick up a pin and use a sewing needle with the right hand. That we have obtained so satisfactory a result is no doubt a good deal owing to the fact that the limbs had retained a sufficient amount of power to prevent their being entirely disused in the long interval during which no treatment was adopted. But the case also shows the value of treatment directed to the nutrition and exercise of the individual paralysed muscles; for the child had been using her paralysed limbs as best she could during several years without the least improvement, whereas the systematic measures adopted in the hospital have been soon followed by a gratifying amount of success.

A CASE OF

MYXŒDEMA ASSOCIATED WITH INSANITY.

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THE following case, which has been under treatment since July, 1881, and fully recognised as one of myxœdema, is of such interest as to demand publicity at the present epoch in the history of this novel disease.

A. R——, aged fifty-six years (1881), the wife of a blacksmith at Dover, was admitted into the Kent Lunatic Asylum at Chartham, July 21st, 1881 suffering from mania, the duration of which on admission was fixed at six weeks. Her father died, about eighty years of age, suddenly, cause of death unknown. Her mother died of heart disease, aged seventy-five. A sister is stated to have starved herself to death twenty years ago. Of a family of six, the patient and one sister are living at date of admission. She married at twenty-six years of age, and has had three children; two are living, and one died of diphtheria. She had scarlet fever when young, and has suffered from palpitation and debility as long as she can remember. She has always been of abstemious habits. Towards the close of 1880 she was considerably worried in her domestic relations; and about this time her face became altered and apparently slightly swollen; her neck also was somewhat enlarged and full. In February, 1881, she had an attack of facial erysipelas, resulting in an abscess of the left temporal region, the scar of which is still evident. She subsequently experienced neuralgic pains in the arms, hands, and legs, and found she was slow in getting through her work. Facts indicating insanity on admission: "Delusions; hears voices of departed spirits; they speak to her and are sometimes very abusive, at other times pleasing. Refuses to answer questions on other subjects. She never performs any of her household duties properly. On several occasions she has walked the streets all night, and once she ran round the garden with only her night-dress on. She refuses to sleep with her husband, as the spirits tell her it is wrong to do so. She is constantly conversing with these spirits, and sometimes will barricade a corner with saucepans, kettles, &c., to keep the spirits away." Has weak health. Heart and lung sounds normal. Œdema of face and extremities. No albuminuria. Weight 8st. 11 lb. During residence in the asylum I have noted specially that in February, 1882, she had an attack of bronchitis. On April 26th, 1882, she weighed 10st 1 lb.; she

was then anæmic; had marked œdema of eyelids, not pitting on pressure; complained that her feet and legs were at times swollen. No albuminuria. From Sept. 13th to 28th, 1883, she was confined to bed with autumnal diarrhœa, and again from Oct. 6th to Oct. 11th. Her weight at present time, Feb. 20th, 1884, is 9 st. 8 lb. She is fairly nourished; the heart sounds are distant, but weak; no bruit. Pulse 60 in semi-erect, 52 in recumbent posture; regular and small. In the sphygmographic tracing, which gave best result with two-ounce pressure, each pulsation is merely a repetition of the previous one, agreeing in duration, regularity, and in its component parts. The striking features of the record are the limited duration of the systole relatively to the diastole, the less than normal height of the percussion wave, its oblique direction, and the almost entire absence of the normal pointed apex. Lung sounds distant, otherwise normal; respiration 14 in the minute in semi-erect, 10 in recumbent, posture; temperature in axilla 93·6°, in the mouth 94·4°. The amount of urine voided in the twenty-four hours was twenty-nine ounces and a quarter, this being the average of four days in December; sp. gr. 1012, rather opalescent from suspended mucus, of pale colour; quantitative analysis in parts per thousand: urea 10·11, uric acid 0·91, phosphates as P_2O_5 1·74, chlorides as NaCl 7·69, sulphates as SO_3 2·21, acidity 2·26 (expressed as oxalic acid); no albumen; no sugar. The urea was estimated by the hypobromite method with all precautions for equalising the temperatures. Her general aspect is dull, apathetic, and renal-like, with sad and almost vacant expression. The size and conformation of the cranium are natural; the hair of the scalp is deficient, very scant on vertex and forehead, lank in appearance, of brown colour, not largely interspersed with grey; the scalp

is glazed and waxy, with here and there semi-detached squamæ; its subcutaneous tissue is infiltrated. The face is swollen, of waxy anæmic hue, with the exception of a livid flush on either cheek, slightly more evident on the left, well-defined externally, and extending upwards and inwards to the orbits. Permanently dilated capillaries are visible in the centre of the cheek flush. Blushing or temporary increase of the flush occurs under excitement and after food, when a pink tint is added to the livid hue. The transverse wrinkles of the forehead are not effaced, but many of the smaller linear facial rugæ are wanting. The eyebrows are deficient almost to absence, the superciliary ridges are gone from infiltration of the neighbouring tissues. Opposite the line of junction of the outer and inner portions of the orbicularis palpebrarum there is a scar-like raphe in both lids; that of the right eye is less distinct than that of the left. The organs of sight appear sunken from the œdema of the lids, and the loose condition of the skin here contrasts markedly with the subcutaneous thickening. The upper lid is more infiltrated than the lower. The eyesight is fairly good, objects being distinctly seen but slowly comprehended. There is no arcus senilis; the pupil is somewhat contracted, and acts slowly to the stimulus of light. The alæ nasi are thickened, and the nose in consequence appears broader than natural, and flattened out; the cheeks are œdematous; the ears are remarkably anæmic, waxy, and translucent. The lips, especially the lower, are hypertrophied and cyanotic, the teeth that remain (lower central and one lateral incisors, and one stump of left upper central incisor) are covered with an abundant, adherent tartar, and are loose; the gums are receding and œdematous. The tongue is large but healthy looking, the mucous membrane of the palate pale and flabby. There is a little fulness in the lower part of the posterior triangle of the neck, but no definite atrophy of the thyroid gland. The skin generally is dry from deficiency of cutaneous secretion, glazed and waxy-looking, over the body, back, and upper part of thighs, with here and there cyanosed veins traversing it. A xerodermatous condition obtains over the elbows, heels, and soles of the feet; elsewhere there is a tendency to scurfy desquamation. The general conformation of the hands is fairly normal, but at times they swell somewhat. The hair of the axillæ is gone, the hair-follicles have atrophied and disappeared; there are, however, in each axilla a number of black tipped minute papillæ, which on removal present to the microscope translucent sudoriferous glands, with circumambient epithelium, cholesterine plates, and crystals of stearates. The pubic hair, and that external to the labia majora, is very limited in amount and lank in appearance. The mental state presents delusions in connexion with sensation, special and ordinary. She has seen moving shadows at night of human shape. She hears tappings, voices, and sounds of engines; she has a bitter taste in the mouth intermittently, but mostly after food, and during varying periods of the day. She smells very disagreeable odours frequently, but not continuously. She experiences sensations over the surface of the body which she is unable to explain. She cannot distinguish sensations of cold and warmth. Ordinary sensation is unimpaired; the tendon reflexes are normal; electric excitability is not deficient. The muscles are not atrophied, and they retain their power. The gait is somewhat tottering, and the movements seem to lack coördination. Speech is slow and measured, but very correct; the voice is hoarse; the mind is slow to comprehend, slow in thought, slow in the expression of its ideas. The actions are therefore slow, and the apparent lack of muscular coördination must be attributed to deficient rapidity of action of muscles, and not to diminished nervous or muscular power. The memory seems fairly good, both for the events of her early life and those of recent date. Formerly she could write, now she is unable to. She sleeps during a large portion of the day with her head bent forwards. I should add that during the close of 1880 and during 1881 she frequently suffered from occipital headache.

Remarks.—The history of this case agrees in the main with those previously recorded. The malady appears to be at present in a comparatively early stage, the spade-like hands being by no means conspicuous, and, as far as one can judge, the thyroid body not having undergone decided atrophy. Some points worthy of note are—(1) The increase of weight from 8 st. 11 lb. in July, 1881, to 10 st. 1 lb. in April, 1882, and subsequent loss, the weight being 9 st. 8 lb. in February, 1884. This loss may be attributed mainly to the two attacks of diarrhœa recorded last autumn. She is now increasing again. (2) The diminution of the pulse rate, respiration and body temperature. (3) The relatively small amount of the urine, twenty-nine ounces and a quarter, being the average of four days' excretion in December. The urea is also diminished by more than one-half, and the acidity of the urine is always marked, in one experiment being 2·26 expressed as oxalic acid. (4) The atrophy and exfoliation of the hair-follicles, sudoriferous and sebaceous glands, and the loosening of the teeth owing to the recedence of the gums. (5) The mental state is undoubtedly interesting, and is, I think, capable of a sufficient explanation. The hebetude and excessive tendency to sleep must be attributed to the lowering of the pulse rate, the diminished cerebral blood-supply, and the probable deposition of mucin in the external arterial tunic. The nutrition of the nerve cells is in consequence interfered with, impressions on the organs of sense, special and ordinary, combined with altered circulation in these organs and peripheral œdema, cause the illusions present, and these from the torpor of the mental faculties readily become delusions. It will be noted that the organs of sight, hearing, taste, and smell are all affected, the peripheral extremities of the nerves of special sense in the mucous membranes of the nose, tongue, and palate being altered by the myxœdema. The peripheral extremities of the nerves of ordinary sensation are similarly affected. The chilliness may be owing to the diminution of the body

temperature, and in process of time loss of appreciation of sensations of cold and warmth results. There is no definite intellectual failure, therefore probably no numerical atrophic changes in the cerebral nerve cells; the nerve force is only diminished in quantity and in the rate of its discharge.

In the contemplation of this disease one is struck by the remarkable analogy to certain lesions of the sympathetic system, and the idea suggests itself that myxœdema may result from a paresis of this system; in support of which I would draw attention to the following facts:—1. The sphygmographic tracing in this case is exactly similar to that produced experimentally by passing a strong continuous current along the middle and inferior cervical ganglia of the sympathetic; when the line of ascent is rendered more oblique, the pointed apex almost entirely disappears, and the duration of the systole relatively to the diastole is greatly diminished. There is also a diminution in the pulse-rate of from four to sixteen beats (Eulenberg and Guttmann). 2. Graves's disease, or exophthalmic goitre, is characterised by increased rapidity of cardiac action, enlargement of the thyroid, prominence of eyeballs, dilated pupils, increased cutaneous secretion, and irritability of temperament. This is the very antithesis of what obtains in myxœdema, in which diminished cardiac action, atrophy of the thyroid, retraction of eyeballs, contracted pupils, diminished cutaneous secretion, and marked tranquillity are prominent symptoms. Again, Graves' disease is, I believe, confined to early adult life. Myœdema occurs at a more advanced age, when the store of vitality is becoming exhausted and degenerative changes ensue. Furthermore, exophthalmos has been induced experimentally by the slight stimulation of the cervical ganglia of the sympathetic in animals. 3. After the complete removal of the thyroid body, a state in every way similar to myxœdema has been found to supervene, named by Prof. Kocher "Strumipriva." May not this be accounted for by the section of the numerous branches coming from the middle and inferior cervical ganglia of the sympathetic (especially the former) of either side to this gland, which intercommunicate in its substance, and which are removed with the gland, thereby causing degenerative changes in the corresponding ganglia? These branches must form, to a large extent, the main line of connexion between the middle and inferior cervical sympathetic ganglia of the one side and the other. As a consequence of degenerative changes in the ganglia, the heart's action would be rendered slower, through the loss of power in the cardiac branches of the sympathetic coming from these ganglia, while the regularity of its action would not be interfered with, that being dependent on its special ganglia. 4. Excessive stimulation of the middle and inferior cervical ganglia of the sympathetic results, through the medium of the cardiac cervical sympathetic branches, in retardation of the heart's action, its regularity, for the reason above stated, being unimpaired. 5. Jaborandi has been found of service in myxœdema. Now, jaborandi acts by stimulating the sympathetic system, and probably in this disease by restoring somewhat the rapidity of the circulation and respiration, the tissue changes and temperature, thereby improving the quality of the blood. 6. In the cases which have resulted in "Strumipriva," the thyroid has been removed for advanced disease of its tissue. Surely no great change of the blood and tissues can result from the removal of an organ rendered comparatively useless by disease. I would, in connexion with the thyroid, note the fact of its large size in the new-born infant (at which period the sympathetic exercises greater sway), when the proportion to the body is as 1 to from 240 to 400, whereas in the adult the proportion is 1 to 1800. This is not without its significance, as showing the intimate connexion of this body with the sympathetic ganglia. 7. The ascertainable cause of myxœdema is generally, as in this case, some nervous depression, worry, domestic anxiety or affliction, pecuniary losses, &c.

In the case of A. R—— we have the sequence, worry, nervous depression in a neurotic subject (she suffered from palpitation and debility in early life), erysipelas of face and neck, neuralgic pains, myxœdema. Brown-Séquard has shown that paralysis of the sympathetic of the same side follows irritation of the surface of the brain. 8. In many of these cases of myxœdema there is an early stage of the disease nearly allied to exophthalmic goitre. There is, then, a striking analogy between myxœdema presumably affecting the sympathetic system and general paralysis of the insane affecting the cerebro-spinal grey matter. We can compare them side by side, thus:—

Cerebro-spinal. (General Paralysis of the Insane.)	*Sympathetic.* (Graves's Disease—Myxœdema.)
1. Stage of increased function and cell nutrition, with grandiose mania.	1. Stage of increased function and cell nutrition, with symptoms like Graves's disease.
2. Stage of commencing nerve atrophy and diminished function, with excessive formation of fat in the connective tissues.	2. Stage of commencing nerve atrophy and diminished function, with deposition of mucin in the connective tissues (myxœdema).
3. Stage of advanced atrophic nerve change, with dementia and paresis.	3. Stage of advanced atrophic nerve change, with mental torpor and paresis of the sympathetic.
4. Neurotic origin, prolonged course, temporary periods of improvement, but fatal issue.	4. Neurotic origin, prolonged course, temporary periods of improvement, but fatal issue.

What connexion can there be between paresis of the cervical sympathetic and the deposition of mucin in the tissues?

It seems to me that the following sequence of events obtains, each bearing to that succeeding it the relation of cause to effect—(*a*) some neurotic influence in a person predisposed to its agency; (*b*) atrophic lesions of the cervical sympathetic ganglia, with paresis of their cardiac branches; (*c*) retardation of the heart's action and blood flow, with alteration in the composition of the blood consequent thereon, the formation of mucin as a retrograde derivative of blood albumen, this mucin being held in solution by the alkaline blood; (*d*) transudation of mucin from the vessels, deposition of it in the external vascular tunic and in the connective tissues.

In conclusion, I would state that I merely offer these suggestions as the outcome of the study of the case which has been under my individual notice, knowing full well the many difficulties that beset the paths of all scientific investigations, but trusting these ideas may be of some slight service in the elucidation of this interesting disease.

Chartham, near Canterbury.

A CASE OF MYXŒDEMA.[1]

BY ERNEST H. JACOB, M.D., M.A.,
ASSISTANT-PHYSICIAN TO THE LEEDS INFIRMARY.

E. R——, aged thirty-two, applied for treatment at the Leeds Dispensary on Sept. 26th, 1883, complaining of swelling of the feet and abdomen. She was visited at home for a short time, and attended as out-patient on Nov. 6th, when the following notes were taken. She had good health till four years ago, when soon after a confinement she noticed some general swelling of the body, and she began to lose strength. This continued, without causing much trouble, for about two years, when she had a miscarriage. Since then the symptoms have been more marked. There has been a general swelling of the face, abdomen, and legs, the feet becoming slightly œdematous at night. Her friends have observed a great change in the appearance of her face. She has become very deaf, and her memory has somewhat failed; she has suffered severely from occipital headache, and her hair has fallen. There is no history of syphilis. On examination, she was about five feet high, of somewhat squat build; complexion sallow, with faint bluish-red flush on cheeks; lips thick and pouting and rather blue. There was an elastic fulness well marked over face and neck, especially in the supra-clavicular region, but no real œdema. Her hands and forearms were covered with a thick, hard skin, very rough; the skin of the palms was fissured, and she complained that she could not make her hands look clean by washing. This was less marked in the legs and feet. Her abdomen was prominent and the walls thick, but nothing abnormal could be felt. She never perspired, and always felt cold. The digestion was good, the tongue fairly clean, and the bowels somewhat

[1] A paper read before the Leeds and West Riding Medico-Chirurgical Society.

confined. The urine was generally of low specific gravity, rather copious, and contained less urea than usual; occasionally a trace of albumen was found. She was moderately intelligent, but there were signs of general weakness in the nervous system. Speech was slow, and somewhat laboured. She said she occasionally "loses herself" for a few seconds. The patient was very deaf; she could hear a loud voice, but not a watch pressed to her ear. The reflexes were normal. There was some general loss of cutaneous sensibility, and the floor felt soft as she walked. She could stand with her eyes shut. The hands felt cold, numbed, and painful. There were no marked signs in the heart and lungs. No thyroid could be felt. She was treated at first with iodide of potassium, under which she seemed to improve, and said she felt steadier. She was then given nitrate of pilocarpine in doses of one-eighth of a grain, which caused some slight moisture on the skin, and appeared to increase her comfort considerably, but of late she has somewhat relapsed, and I do not think she is much better than when I first saw her. She complains principally of severe occipital headache.

Leeds.

A CASE OF EPILEPTIC AUTOMATISM.

BY SOLOMON C. SMITH, M.D.,
SURGEON TO THE HALIFAX INFIRMARY.

THE following is an interesting example of epileptic automatism:—

A young man has for four years been subject to attacks of petit mal. He does not fall, but seems to "fix" his eyes, and sometimes walks forwards, or sideways, at others sits down, and generally ends by going to sleep. There are neither convulsions nor frothing at the mouth, nor tongue biting. The only warning is that he suddenly begins to wonder whether he is going into an attack, and then he loses consciousness. He does not think he ever dropped anything out of his hand, but he has spilt tea out of a cup. In some of the attacks he will stop what he is doing and seem to "study" for a time, but in others he will go on doing what he was engaged in at the time.

A. On one occasion, while alone in the house, he had been playing the oboe, and was just turning over some music when he lost himself, and knew nothing more for an hour and a quarter (he happened to know the time); when consciousness returned he was lying on the sofa still alone in the house. He, however, must have, during the state of unconsciousness, put the oboe properly away in its case and taken out the reed, for it was uninjured in its place when he came to himself. Now, this taking the reed out of an oboe is an operation requiring very delicate manipulation.

B. Another day he was with several musical friends. I think he had been accompanying some of them on the piano. He was standing at the table turning over some pieces of music when they saw him go into an attack. While it was obvious to them that he was in a fit, for they had seen him before, he took up a piece of music, went to the piano, and played it; he was quite unconscious afterwards of having done this.

C. In his father's mill there is a machine for winding warps, which is not under the special care of anyone, for, when started, it works for some time by itself; but occasionally a warp breaks, and when this takes place anyone who happens to see the broken end of the warp hanging down stops the machine, "piecens"—i.e., joins—the ends, and starts the machine again. Now, one day his father and others saw him go into an attack ("fix" his eyes and walk forward); and while he was in it he passed this machine, in which a broken warp was at that moment hanging down. He stopped the machine—which is a peculiarly complex action, for it must not be stopped suddenly, but has to be let down or "slowed" by degrees—he tied the broken ends, and then started the machine again. All this he did while obviously quite unconscious, and then he passed into the usual drowsy ending of the attack.

These are good illustrations of the complexity of those automatic actions which often occur during epileptic unconsciousness. It is important, however, to recognise that they did not constitute the fit, but took place in spite of it; it was in no sense purposive epilepsy; the patient's actions were purely automatic, occurring in response to stimuli reflexed through centres lower than those involved in the discharge. If this be limited to parts essential to higher consciousness only, and lower areas are left untouched, these, being freed from control, will, according to Dr. Hughlings Jackson, act automatically, sometimes with even hyperphysiological activity, in response to any stimuli which fall in their way, which may, as was possibly the case in *A*, be the remains of intentions already cerebrally formulated, or may be sense impressions received while in the unconscious condition, as was certainly the case in *C*. The apparent rationality of the actions is confirmatory of the opinion expressed in the recent Croonian lectures—that in the "dissolution" of epileptic discharge "the lower level of evolution remaining—the then highest level—is of some part of the highest centres," that the middle and lowest centres are of course in activity, "but are put in activity by what remains of the highest." *A* illustrates the great delicacy of touch and manipulation which may be exercised; *B*, that such an art as music may be practised, an art requiring the use of memory in a high degree; and *C*, that a sensory impression received during the condition of automatism may set up a fresh and most elaborate series of movements, which are performed with accuracy and perfect appropriateness. These have been spoken of as post-epileptic, the suggestion being that the automatism occurs after the paroxysm, but as somewhat similar phenomena (i.e., non-convulsive, apparently purposive acts) sometimes occur very early in the attack, even before a convulsion, we must believe that all that is necessary for their production is that discharge should occur in those nervous structures whose interlacements form the physical substratum of consciousness, while the reflex circles (or more truly mazes) required for the particular automatic actions of the case are intact, whether as the result of non-implication or of prior recovery is a matter of indifference, as it also is whether the discharge in the upper layers still goes on or not. There is this great difference, however, between the actions at the two extremes of the attack; in those which are post-epileptic external suggestions obviously play a part, so that the resulting phenomena vary in the different paroxysms of the same individual, but the early movements which take place at the commencement are apt to be repeated each time in nearly the same form, and so to seem really to constitute part of the fit itself. When, for example, a girl rushes into the street tearing at her dress and shrieking that she has rats inside her, and then falls into stupor, or when a man while conversing suddenly begins to undress, and this ends in a convulsion, and when in each case the same sequence of events recurs every time, the repetition of the same phenomena negatives their dependence on external and therefore varying stimuli, and suggests, wrongly as I think, that the action is part of the fit, the direct result of the discharging lesion. Notwithstanding the exactness with which it has been found possible to map out the convolutions into motor areas, it must not be concluded that either they, or the deeper parts with which they electrically correspond, are centres capable of initiating the movements which result from their stimulation, or that there exist centres at all for more elaborate acts; all we can say is that where cerebral activity results in certain movements, the impulses largely pass through certain corresponding areas. But these impulses come from no one part of the brain; they are partly sensory, partly reflex, partly volitional, and therefore imply activity of widespread regions, so that although irritation of a motor centre may produce a localised convulsion, it is impossible to conceive that a discharging lesion of any part of the brain could lead to the complex cerebration necessary for the production of the elaborate actions of epileptic automatism. These are, as Dr. H. Jackson has shown, the result of the activity of the remainder, which may have just been "set" to carry out some intention already cerebrally formulated at the moment of suspension of consciousness, or may be directed in certain grooves by sense impressions, either from without or from the viscera, or may be influenced by various subjective sensations produced by the discharge itself. In epileptic attacks consciousness departs in various ways, and its total abolition is often preceded by steps of less and less perfect relation to the environment—in other words, by a series of subjective sensations. When these develop slowly and are remembered they form the aura, but it is impossible to say how far into the fit they may extend, and they would be as likely to give rise to automatic action as would external sense impressions. Dr. Hughlings Jackson had a boy under his care who was

subject to fits beginning by a subjective sense of smell: "It was an interesting and important fact that he would hold his nose when the fit began. No doubt as his consciousness became obscured, 'he' believed the smell was of something actually outside. It is perhaps too strong an expression to say *he* believed, for where is the 'ego' when a man is unconscious, or partly so? We may say the smell developed an epileptic dream. I had a woman under my care who at the beginning of an attack had 'subjective' sensations of smell, who said, 'What a dreadful stink there is in the place!' She believed the smell was of something in the room."[1]

In these cases the actions were obviously the result of the purely subjective sensation of smell, and in the boy's case went on into the unconsciousness; and it seems extremely probable that, when, as the first act of a fit, some one thing is always done, such as in the case of the man who takes his clothes off, or the girl who rushes out in terror, this is an automatic action started by some subjective sensation arising during the abrogation of consciousness; even the scream which so often heralds the attack may be caused by some great horror felt but not remembered. The theory, again so ably enforced by Dr. Jackson in the recent Croonian lectures, that the epilepsy is responsible for the convulsions and unconsciousness, but that the unfettered activity of the remainder of the brain is the cause of the post-epileptic phenomena, is of the greatest service in comprehending the disease. It perhaps simplifies things still further to look at all purposive acts, at whichever end of the attack, as due to the same cause.

Halifax.

NOTE ON THE TREATMENT OF CORYZA.

BY G. E. DOBSON, M.A., M.B., F.R.S.,
SURGEON-MAJOR, ARMY MEDICAL DEPARTMENT.

THIS very troublesome complaint has scarcely received the attention it deserves, if we take into consideration the great number of sufferers and the serious laryngeal and pulmonary diseases to which it is too often a prelude. Amongst the host of remedies proposed for its abortive treatment, most of which are either of doubtful value or else difficult to procure or apply, or even dangerous to use, not one can be named of which it may be said that it is at every one's command, easy of application, unattended with danger, and really effective. No excuse is, therefore, needed in introducing to the notice of the profession the following simple yet thoroughly effective mode of treatment, which in my hands has never disappointed expectation. About a drachm of camphor, coarsely powdered, or shredded with a knife, is placed in an ordinary shaving jug, which is then half filled with boiling water. The patient, having made a paper cone (out of a sheet of brown paper or an old newspaper) large enough to surround his face by its wide extremity and the mouth of the jug by its narrow end, proceeds to respire freely, at each inhalation drawing the steam into his nostrils, and at each exhalation forcing it up against the outer surface of his nose and adjoining parts of the face. A twofold action is produced: the camphorated steam acts internally in a specific manner upon the whole extent of the mucous surfaces, and, externally, produces profuse diaphoresis of the skin covering the nose and sides of the face, there acting as a derivative from the inflamed Schneiderian membrane. The jug should be surrounded by a woollen cloth in order to prevent the water cooling, or, better, if a tin shaving-can be used, a small spirit lamp or heated iron may be placed beneath it, so as to maintain the heat of the water and the vaporisation of the camphor. The patient should continue his respirations (keeping the margins of the base of the paper cone closely applied round his face) from ten to twenty minutes, and this should be repeated three or four times in as many hours, till entire freedom from pain is experienced. Great relief is always felt even after the first application, and three or four usually effect a cure. Camphor, or some of its preparations, have, as is well known, been long in use in the treatment of colds, but the above-described method of employing it in conjunction with the vapour of water both as an internal and external application at the same time, has not, so far as I know, been previously brought to the notice of the profession, or, if brought, has not been recognised in any general or special medical work. The mode of application is, however, all important; but as this is neither troublesome nor otherwise unpleasant to the patient, nor are the materials difficult to procure, camphor being everywhere a household drug, I believe that those who may give this treatment a trial will find it not only a simple, but also a most effective, remedy against coryza.

[1] West Riding Asylum Report, vol. v.

ON ACNE IN FIBRE-DRESSERS.

BY CHARLES ATKIN, L.R.C.P.LOND., F.R.C.S.,
HOUSE-SURGEON TO THE SHEFFIELD INFIRMARY.

A DERMATITIS taking an acneform character, arising from an external irritant, is certainly uncommon. "Eczema," so called, in its various stages, is met with in many trades and occupations in all its varieties, from the "weeping vesicle" to the "leathery scaling skin"; but rashes of a tubercular form arising from external irritation of the hair-follicles have hitherto, as far as I know, been limited to those who work with tar, paraffin, benzoin, &c., or those cases where tar has been energetically used to cure some other form of skin disease, as psoriasis or chronic eczema. During last summer my attention was directed to a form of rash on the forearms and thighs of a certain class of workmen different from anything else I had ever seen in those situations. The first case met with was in a healthy-looking, intelligent man, aged twenty-four, who described himself as a fibre-dresser, at which special department of brush-making he had been employed for the last two years. His work consisted in dipping a fibre called "kitool" and cocoa-nut fibre into some special preparation of various oils, soaking it, and then tearing and pulling it out. Since he has been employed at this work he has suffered continually from a rash, which itches and is sometimes painful. His forearms were more or less covered with raised tubercles, discrete, and presenting all the stages from the "black point" of the closed sebaceous gland to the suppurating, tense, and painful nodule. There were no pustules on the backs of the hands, but the "black points" were universal, and could be extruded by pressure or picked out by a needle-point. Wherever pustules had been were well-marked scars. The hairs on the backs of the forearm were scanty, and could easily be pulled out with forceps, without any pain whatever. The same condition existed on the front of the thighs and shins, but more especially on the knees. There was no appearance of acne on the face, and only very scantily on the shoulders. Under the microscope the hairs treated with solution of potash were seen to be very swollen at their roots, with much adherent epithelium, evidently from proliferation of the lining of the hair-follicle. The man being otherwise healthy, with no appearance of struma, syphilis, congenital or acquired, or scorbutus, the rash was evidently connected with his work. On being questioned, he informed me that he continually got his trousers soaked in front in dipping the kitool, and that he worked with his coat off and his sleeves rolled up. The next question was, What was the cause of the rash—the fibre or the oil? The former, which is a kind of coarse dried grass, produces no local ill effects on those who simply sort and pick it, causing only some throat irritation from the quantity of dust arising from it; therefore the cause evidently lay in the liquid used. On procuring a sample of this I detected a smell of paraffin in it, and learnt on inquiry that it was not unusual to have this special oil mixture adulterated with this material. On visiting the place where the man worked, I found that all the men engaged in a similar occupation had acne more or less on their forearms, and that those who had been employed for some length of time were nearly absolutely hairless on those parts. Hebra says that when a rash is due to paraffin &c., it does not usually come from direct contact of the irritant with the skin, but by the person living in an atmosphere impregnated with its vapours; such, however, can hardly be the case here, for the rash is strictly localised to those parts which come in contact with, or are saturated by, the fluid, and also by the fact that it does not occur in those who only sort the fibre, though they are often at work in the same room. Again, it differs from acne caused by tar in that, Hebra says, the rash disappears on discontinuance of the irritation, leaving neither maculæ nor scars. Here the rash, though was told it very much

improved during a week's stay in the country, left most indelible marks of its former existence. Why should substances like mercury and antimony, acids, croton oil, cantharides, turpentine, and mustard applied locally produce an eczematous dermatitis, whilst paraffin causes an acne? The paraffin has apparently a very irritating effect on the hair-follicles and their adjacent sebaceous follicles, as they seem to be primarily affected; but why should not turpentine be equally so? The mildness and chronicity of the application may account for it; for it is well known that vegetable irritants cause a more acute form of dermatitis than the mineral ones, but that does not explain why the local application of mercury should not cause an acne as well as a papular eczema. In confirmation of the irritating properties of paraffin, Dr. Longmuir[1] pointed out that epithelioma not uncommonly occurs in those who have to handle and work with it, but he does not mention whether he has noticed acne also. The fact of both acne and cancer having been attributed to the same irritant, suggests the question, Does traumatic acne ever go on to traumatic carcinoma?

Sheffield.

STRANGULATED HERNIA IN AN INFANT.

OPERATION; RECOVERY.

BY WILLIAM DOBBIN, M.A., M.D.

ON the afternoon of Thursday, Feb. 14th, 1884, I visited a dispensary patient, Jas. S——, aged six months, the child of a mill-worker residing at Ballykeel, near Banbridge. He was a rather small child and had been born about six weeks prematurely, but appeared well-nourished. The mother stated that nothing would lie on his stomach and that there had been no motion from the bowels since Tuesday, and the look of the child indicated suffering. When the patient was undressed that I might inspect the abdomen, I observed that the right side of the scrotum was distended by a tumour the size of a hen's egg, which on examination proved to be a strangulated hernia. The hernia had first appeared when the child was six weeks old, and used to come down at intervals and go back again of its own accord. When it was down the child suffered from what the mother described as "colic." Failing to reduce the hernia, I ordered a linseed-meal poultice to be applied to the part so as to relax the tissues, and left, promising to return in the evening. Between six and seven I again visited the patient, accompanied by my friends, Dr. Smyth, J.P., and Dr. Tweedie, who concurred in the diagnosis. It was decided to give chloroform and carefully try the taxis, and if not successful in effecting reduction to operate at once. The taxis diminished the size of the tumour, and the scrotum became quite soft and lax, so that the testicle could now be distinctly felt, but there still remained a firm swelling in the groin, on which no impression could be made. I then proceeded with the operation, which I may remark was done by candlelight. The sac was reached without difficulty; but reduction being still impossible, it was opened, when a quantity of blood-stained serum escaped and a knuckle of dark-coloured intestine was exposed, which was tightly constricted at the external ring. The stricture was carefully notched and the bowel returned. The wound was closed by three silk sutures, a very narrow strip of carbolised lint having been introduced at its lower end, to serve as a drain. Carbolised lint was applied and a pad and bandage. About an hour after the operation the little patient passed a copious motion of healthy but very offensive fæces. Feb. 15th: Bowels opened twice; still some vomiting.—16th: Wound dressed, looking healthy; occasional vomiting; bowels opened.—17th: Wound dressed; all vomiting ceased. The sutures were removed on the fifth day and the wound was dressed with zinc ointment. Granulation went on steadily and the wound was soundly healed in about a fortnight. A truss was applied in a few days and the child continues in excellent health. No medicine was given at any time.

Remarks.—The only point of difficulty or obscurity in this case was the lessening of the tumour by the taxis under chloroform; but the persistence of the swelling outside the external ring, which was much more obvious when a comparison was made with the other side, showed that the hernia had not been reduced. This case is only another confirmation of the principle of operating immediately when the taxis has failed. Delay is dangerous, and tends to bring operative surgery into disrepute. Although operations for strangulated hernia in infants have been done repeatedly, they are not very common, especially in country practice, and the successful result of this case may strengthen the practitioner in urging an operation even in a labourer's cottage, where the space is limited and the surroundings are not all that could be desired.

Banbridge, County Down.

[1] Vide the Edinburgh Journal of Dec. 1883.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nullas autem extalia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum propriis collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

MIDDLESEX HOSPITAL.

CASE OF ABSCESS OF THE LIVER FOLLOWING DUODENAL ULCER; NECROPSY; REMARKS.

(Under the care of Dr. DOUGLAS POWELL.)

FOR the following notes we are indebted to Mr. Edward Stewart, L.R.C.P., M.R.C.S., resident physician's assistant.

A well-nourished, grey-haired man, aged fifty-four, with yellowish tinge of skin, was admitted on December 22nd, 1883, complaining of constant shivering and paroxysmal pain across the abdomen. His family history was good, and as regards his personal history, with the exception of rheumatic fever sixteen years ago, he had not had any serious illness. The symptoms of the present illness first appeared about three weeks before admission. During this time the patient had shivering almost constantly, and paroxysmal pain in the abdomen, with dry tongue and general malaise. He had noticed his face had been getting yellowish for about ten days.

State on admission.—Pulse 96, regular; temperature 98·8°; respiration 24. Conjunctivæ yellow. Arcus senilis marked. Tongue furred and furrowed on dorsum. The abdomen appeared full and rather tense. The liver dulness in the nipple-line began at the sixth rib, and extended to half an inch below the umbilicus; the left margin extended two inches below the cartilages; the surface was smooth and firm. The other abdominal organs were healthy. Bowels confined; motions light grey in colour. There was bile in the urine.

December 27th: Evening temperature rose to 101·4°; pulse 100. Bowels open twice, motions light grey in colour, one being passed unconsciously. On the following day it was noted that the percussion note at the right posterior base of the thorax was less full, respiration feeble with subcrepitant râles; tongue very dry and furred.—29th: Some diarrhœa; one motion being passed during sleep, and it was noted that the liver dulness began at the fifth rib in the nipple-line, and the margin was felt one inch below the cartilages. The abdomen was distended but not painful. At the right nipple level resonance was wanting in fulness, and here as well as in the axilla the heart sounds were unduly conducted. Respiration, however, was well heard in front down to the base.—30th: At 11 P.M. the temperature was 103°; pulse 136; the patient was sweating freely and seemed drowsy, and one of his motions contained some blood. Next day the abdomen was more distended and the patient had several small rigors; dulness at the right posterior base extended over the four lower ribs. In consequence of these symptoms a small trocar connected with a syringe was introduced into the dull area, but only a few drops of blood-stained fluid were withdrawn.

On January 7th the patient had a rigor lasting a quarter of an hour. Temperature after rigor 102·6°. Three days later he had two severe rigors, temperature afterwards being 103°; patient very drowsy and passing excretions involuntarily. On January 11th, pulse 136, respiration 40, and there was another severe rigor. On the 12th, respiration 44, pulse 120, small, feeble, and compressible. The patient became very apathetic and died in the evening.

Necropsy.—Sixteen ounces of fluid were found in the

peritoneal cavity. On opening the second part of the duodenum, a small circular ulcer, the size of a shilling, was discovered at the orifice of the pancreatic and bile-duct; the surface was smooth and it had undermined edges, and on pressing the gall-bladder only a small quantity of bile exuded from the duct. The liver substance was congested and soft, and on the surface was a coating of blood-stained lymph. On cutting into the right lobe of the liver the bile-ducts were found distended and full of bile, while some of them had suppurated. Branches of the hepatic and portal veins contained pus. On opening the left lobe some of the ducts seemed to have run together, forming two or three abscesses, each being about the size of a walnut. The joints were not affected.

Remarks.—The repeated rigors, dry tongue, increasing apathy of the patient, with raised and fluctuating temperature, pointed to the presence of suppuration, which the jaundice and increased size of the liver suggested as being in that organ. The absence of any history leading up to abscess in the liver, and the failure on two occasions to obtain pus by the exploring syringe, obliged us to fall back upon some obscure pyæmic condition leading to disseminated abscess. There was no sufficient evidence of gall-stones, nor was there at any time an absolute want of bile in the motions. No more accurate diagnosis was therefore arrived at during life. The result of the post-mortem would seem to show a condition of things analogous to what may be sometimes observed in the kidney in hydro-nephrosis and loculation of the organ, with secondary suppurative changes; or in the lungs in cases in which the main bronchus is partially occluded by pressure or growth, causing loculation of the lung, with dilated bronchi, distended with secretion and sometimes suppurating.

CASE OF HYDATIDS OF LIVER; TAPPING; FREE DRAINAGE; RECOVERY; REMARKS.

(Under the care of Dr. DOUGLAS POWELL.)

For the following notes we are indebted to Mr. Edward Stewart, L.R.C.P., M.R.C.S., resident physician's assistant.

A man, aged fifty-five, but looking rather older, was admitted on Nov. 3rd, 1883, with pain and enlargement of liver. The family history was good. At twenty years of age the patient had rheumatic fever; at twenty-six he had syphilis. He had passed a great deal of time in the western district of Victoria, last visit twenty years ago. Fifteen months ago he first noticed some fulness over the hepatic region, and since then has had considerable pain in the right hypochondrium, and had lost flesh during the last twelve months.

State on admission.—There was obvious enlargement of the upper abdomen. Dulness over the liver extended laterally from the mid-axillary line on the right side to the nipple-line on the left. Downwards it extended in the right nipple-line to two inches below the umbilicus, in the mid-sternal line to the umbilical level, and in the left nipple-line to one inch below the umbilicus. Three firm enlargements could also be distinguished projecting from the surface of the liver—one just below the ensiform cartilages, another just below the cartilages in the left nipple-line, and the third in the right hypochondrium. These enlargements suggested the flattened prominence of growths. The other organs were apparently healthy. The patient continued to suffer pain over the liver, but nothing further was noticed till the 20th, when friction and fremitus over the right lobe of the liver became very distinct.

On Dec. 19th he had an attack of tonsillitis, which, however, soon yielded to treatment. On the 31st the pain in the right hypochondrium was much increased, and for the first time fluctuation could be distinctly felt in the right nipple-line two inches below the cartilages, over the seat of the former prominence, which had become larger and more rounded. Aspiration was therefore decided on, with the result that thirty-two ounces of clear fluid were withdrawn. The fluid had the specific gravity of 1010, reaction neutral, chlorides abundant, no albumen, and on microscopical examination numerous ecchinococci were seen. The patient had a slight attack of syncope after the operation, but otherwise seemed comfortable.

Next day, Jan. 1st, the right side of the abdomen was much less full, and the right lobe of the liver had apparently retracted, but now the swelling below the ensiform cartilage appeared much more prominent. There was no pain, but fluctuation was distinct, and a thrill could be obtained on light percussion.

On Jan. 2nd this swelling was tapped, but only a very little clear fluid was withdrawn on account of the needle getting blocked. On the 4th tapping was again tried, but with no result, the cyst apparently not being so superficial as was expected. The patient did not seem to suffer any ill effects from the punctures; but on the 7th his temperature began to rise, varying from 100° to 101° F. in the evening, and being normal in the morning. On the 11th a small tense swelling was noticed at the extreme left edge of the liver, but no fluctuation could be obtained; the swelling was an inch and a half in diameter. On the 16th this swelling was tapped, and four ounces of slightly turbid fluid were withdrawn; the fluid was alkaline, sp. gr. 1015, chlorides abundant. The microscope revealed ecchinococci and laminated cyst wall, also cholesterine crystals. At this date also it was noticed that in the seventh and eighth cartilages on the left side—that is, the costal margin was bulged and projected from beneath these cartilages to about two inches and a half below their margin in the mid-sternal nipple-line—was a rounded, elastic, slightly lobulated tumour; this was tapped, but only a few drops of fluid were withdrawn, owing to the tube getting blocked by hydatid membrane. On the 21st the patient began to perspire freely at night, and pain with friction was again noted over the hepatic region. On the 23rd it was noticed that the swellings from which fluid had been withdrawn had quite subsided. On the 26th he had an attack of syncope, with blanched, cold surface, and very weak intermittent compressible pulse.

On Feb. 3rd he felt a chill, followed by feverishness, with temperature 102·2°. The pulse remained irregular and intermittent. The liver continued to retract, and on Feb. 7th it was noted that in the right nipple-line it reached to the umbilical level; the margin could not be defined; but on light percussion the abdomen was resonant in the line of the left rectus to two inches above the umbilicus. On the 25th some fulness was noticed between the right nipple and the median line, two inches above the level of the umbilicus.

On March 6th the fulness noticed on Feb. 25th between the right nipple and median line had much increased, and was fluctuating and tender, while a portion of this prominent area was tympanitic on percussion. Two days later the swelling was tapped, and sixteen ounces of horribly fetid, semi-purulent matter evacuated, but it was not considered advisable to withdraw all the contents. On the 10th, after consultation with Mr. Morris, it was decided freely to evacuate and to drain the cyst; ether was therefore administered, and an incision two inches and a half long was made parallel with the ribs; the abdominal walls were then carefully dissected through, bleeding vessels being secured at each step. On the cyst wall being reached it was made secure to the parietes by means of silk sutures, and was then freely opened, thirty ounces of fetid pus being let out. The cavity was well irrigated with iodine, and a large drainage-tube, seven inches long, was inserted, and the edges brought well together with sutures. The patient felt no ill effects from the operation, and from that day improvement rapidly took place, the pulse became regular, sweating at night subsided, appetite good, and the patient quickly gained flesh. The wound was dressed throughout on antiseptic principles, the tube was gradually shortened and finally removed, and on May 2nd the opening had completely healed. The patient left the hospital a few days later, quite convalescent.

In commenting on this case Dr. Powell remarked that it presented several features of interest. 1. When first admitted the multiplicity and hard crater-like feel of the tumours, presenting as yet only deeply from the surface of the liver, suggested malignant disease, a diagnosis favoured by the general aspect of the patient, although grounds for hesitation were afforded by the duration of the symptoms. 2. The smoothness and fluctuation of the tumours, as after a few weeks they came nearer the surface, rendered the change of diagnosis to that of hydatids inevitable. 3. The contraction of the tumours successively after aspiration through a fine trocar of a portion only of their contents, was an illustration of the fact first pointed out by Murchison, that death of the parasites commonly ensued upon even a partial removal of the fluid media in which they flourish, and in the majority of instances was a sufficient as well as a safe treatment. 4. The suppuration which subsequently took place in the largest tumour evidently arose from decomposition of the contents of the sac consequent upon the death of the parasite. Probably "hydatid abscess" always arose in this way. It was a question whether this occurrence might have been avoided had a smaller proportion of the

fluid in the first instance been removed from this cyst by aspiration. 5. The observations early in the case of friction over the liver was of value in affording certain evidence of adhesions being formed between the surface of the liver and the parasites, which at a later period greatly diminished the risks from incising and draining the abscess.

WOLVERHAMPTON AND STAFFORDSHIRE HOSPITAL.

CASES OF HEART DISEASE RELIEVED BY BLEEDING.

FOR the following notes we are indebted to Mr. W. Collier, M.A., M.B. Cantab., late house physician.

CASE 1. (Under the care of Dr. Millington.) — Mrs. A. P——, aged forty-two, was admitted on Aug. 14th, 1883. Six months previous to admission she had got wet through, the exposure being followed in a few days by severe pain across the loins and over the cardiac region, with slight dyspnœa and swelling of the legs and ankles. These symptoms had gradually increased in severity; for the past eight weeks the urine had been scanty. Condition on admission: Temperature 98·4°; urgent dyspnœa; intense cyanosis of lips and face; jugulars greatly distended, with marked pulsation of the carotids; pulse almost imperceptible; respiration 46; great œdema of legs and ankles, some ascites; urine one-third albumen; spoke with the greatest difficulty. Heart: Apex-beat displaced downwards and to the left; area of dulness much increased, especially laterally, and sounds muffled, systolic bruit culminating at apex. Lungs: Over the lower two-thirds of the right lung the percussion note was dull, with increase of vocal resonance and tactile fremitus; a few small crepitations heard over same area. Ordered ten minims of tincture of digitalis with five grains of carbonate of ammonia, to be taken every five hours. To have four ounces of gin daily. On Aug. 16th, shortly after midnight, about thirty-eight hours after admission, as the condition was extremely critical, and as there had been little or no improvement, she was bled from the right arm to the extent of about four ounces, which was almost immediately followed by an improvement in the breathing, and the patient expressed herself as feeling more comfortable. On the following morning a further improvement in the breathing was noticed, and the cyanosis was greatly diminished. On the 18th the amount of urine passed was greatly increased. On the 21st the pulse was 90, small and irregular; respiration 38; percussion note over the right lung more resonant; respiratory sounds clearer, and small crepitation less abundant; general condition greatly improved.—September 3rd: Continues to improve; albumen much diminished; heart sounds loud and irregular; mitral bruit can no longer be heard.—18th: Has been getting up for past day or two; œdema of legs has quite disappeared; ordered sulphate of iron pill three times a day, and a draught of quinine and digitalis three times a day.—24th: Discharged convalescent.

CASE 2. (Under the care of Dr. Totherick.)—Mrs. E. T——, aged fifty, was admitted on Nov. 27th, 1883. For the past eighteen months she had been troubled with shortness of breath on exertion, and attacks of cardiac pain and palpitation. During the past few weeks these symptoms have increased much in severity. At the age of nineteen she had a severe attack of rheumatic fever. Condition on admission: Considerable dyspnœa; anxious expression; lips and face somewhat cyanosed; veins of neck congested. Respiration 38; pulse small and weak (120). Heart: Apex beat diffused, displaced downwards and to the left; area of dulness much increased both in vertical and lateral directions; sound rapid and muffled; short systolic bruit heard over mitral region. Lungs: Physical signs show considerable congestion of both bases. Liver: Area of hepatic dulness much increased, about six inches and a half, in the nipple-line. Urine showed a trace of albumen. A draught of infusion of digitalis, carbonate of ammonia, and spirit of chloroform was ordered, to be repeated every six hours.—Nov. 30th: Dyspnœa diminished and general condition improved.—Dec. 1st: Dyspnœa this morning much increased; lips and face again cyanosed.—12 o'clock (night): Breathing worse than this morning; respiration 52, gasping; cyanosis increased; veins of neck considerably distended. Bled immediately from the right arm; about four ounces drawn off. Pulse at once improved. On the following morning the patient expressed herself as feeling very much better; had had a good sleep during the night. Dyspnœa much less marked. Respiration 36; pulse 104, decidedly stronger. On Dec. 6th the patient left the hospital greatly benefited.

CASE 3. (Under the care of Dr. Totherick.) — Charles L——, aged thirty-three, was admitted on Oct. 25th, 1883. This illness commenced about a month before admission with shortness of breath, followed in a few days by pain and palpitation of the heart, and swelling of the legs and feet. His previous health was very good; he has worked hard at well-digging. Condition on admission: Marked dyspnœa and cyanosis, orthopnœa, œdema of legs and feet. Pulse small and very irregular. Urine contains slight trace of albumen. Ordered tincture of digitalis and carbonate of ammonia, to be taken every six hours.—27th: Dyspnœa increased. For the past two days has been coughing up a quantity of bright aerated blood; pericardial friction present; soft double bruit heard at apex.—30th, 3 A.M.: Breathing much worse; still coughing up bright-coloured blood. Bled from the left brachio-cephalic vein to about eight ounces. No immediate relief in symptoms noted. 11 A.M.: Decided improvement now observed. Heart sounds louder and clearer. Pulse slower and more marked (112); dyspnœa diminished. Patient continued to improve, and left the hospital on Nov. 16th much relieved. Continued free from dyspnœa and other symptoms for three weeks, when he recommenced work, at sheet-iron rolling; in a fortnight all the previous symptoms had returned.—Jan. 5th, 1884: Readmitted to hospital; heart sounds very muffled and irregular; systolic bruit present at apex. The symptoms were for a time much relieved by taking one minim of the 1 in 100 solution of nitro-glycerine every two hours during the day, with digitalis and spirit of sulphate of ether at longer intervals.—14th: Became much worse; signs of fluid present at both bases.—19th: Died. Autopsy showed dilatation and some hypertrophy of the cardiac cavities, with pericardium closely adherent throughout.

Remarks by Mr. COLLIER.—It will be noticed that in the cases here reported the cardiac tonics and stimulants used—digitalis, ether, and ammonia, &c.—had during their two or three days' trial failed to give relief. The chief indications for bleeding were the extreme distension of the right side of the heart, together with the urgency of the symptoms. Bleeding in the first two cases was followed by immediate and marked relief, which relief, as the further history shows, was of a permanent nature. In addition to the immediate benefit, the withdrawal of a few ounces of venous blood by relieving the distension of the right side of the heart seemed to bring into play for the first time the physiological action of the drugs used. In the third case, although the benefit was not so marked as in the other two, it was sufficient to encourage one to adopt the same treatment under similar circumstances.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Composite Temperature Chart of Small-pox.—Gangrene of the Lung treated by Drainage, with Recovery.—Basic Cavities of the Lung treated by Paracentesis and Free Drainage.

AT the penultimate meeting of this Society, held on Tuesday last, Dr. George Johnson, F.R.S., President, in the chair, a lively interest was aroused by the reading and discussion of papers dealing with the subject of pulmonary surgery.

Dr. ERNEST HERMAN read a paper on an Average or "Composite" Temperature Chart of Small-pox. The charts described in this paper were constructed from observations made during the small-pox epidemic of 1871, in a temporary hospital at Shoreditch. These charts are made up by adding together the figures indicating the temperatures in the different cases for the same period of the day, and dividing the total by the number of observations. By this method the average temperature of all the patients is shown from day to day, instead of that of each individual patient, as is the case in ordinary temperature charts.

Dr. CAYLEY read a paper in conjunction with Mr. PEARCE GOULD on Gangrene of the Lung treated by Drainage, with Recovery. The patient was a girl aged twelve, who was

peritoneal cavity. On opening the second part of the duodenum, a small circular ulcer, the size of a shilling, was discovered at the orifice of the pancreatic and bile-duct; the surface was smooth and it had undermined edges, and on pressing the gall-bladder only a small quantity of bile exuded from the duct. The liver substance was congested and soft, and on the surface was a coating of blood-stained lymph. On cutting into the right lobe of the liver the bile-ducts were found distended and full of bile, while some of them had suppurated. Branches of the hepatic and portal veins contained pus. On opening the left lobe some of the ducts seemed to have run together, forming two or three abscesses, each being about the size of a walnut. The joints were not affected.

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On Dec. 19th he had an attack of tonsillitis, which, however, soon yielded to treatment. On the 31st the pain in the right hypochondrium was much increased, and for the first time fluctuation could be distinctly felt in the right nipple-line two inches below the cartilages, over the seat of the former prominence, which had become larger and more rounded. Aspiration was therefore decided on, with the result that thirty-two ounces of clear fluid were withdrawn. The fluid had the specific gravity of 1010, reaction neutral, chlorides abundant, no albumen, and on microscopical examination numerous ecchinococci were seen. The patient had a slight attack of syncope after the operation, but otherwise seemed comfortable.

Next day, Jan. 1st, the right side of the abdomen was much less full, and the right lobe of the liver had apparently retracted, but now the swelling below the ensiform cartilage appeared much more prominent. There was no pain, but fluctuation was distinct, and a thrill could be obtained on light percussion.

On Jan. 2nd this swelling was tapped, but only a very little clear fluid was withdrawn on account of the needle getting blocked. On the 4th tapping was again tried, but with no result, the cyst apparently not being so superficial as was expected. The patient did not seem to suffer any ill effects from the punctures; but on the 7th his temperature began to rise, varying from 100° to 101° F. in the evening, and being normal in the morning. On the 11th a small tense swelling was noticed at the extreme left edge of the liver, but no fluctuation could be obtained; the swelling was an inch and a half in diameter. On the 16th this swelling was tapped, and four ounces of slightly turbid fluid were withdrawn; the fluid was alkaline, sp. gr. 1015, chlorides abundant. The microscope revealed ecchinococci and laminated cyst wall, also cholesterine crystals. At this date also it was noticed that in the seventh and eighth cartilages on the left side—that is, the costal margin was bulged and projected from beneath these cartilages to about two inches and a half below their margin in the mid-sternal nipple-line—was a rounded, elastic, slightly lobulated tumour; this was tapped, but only a few drops of fluid were withdrawn, owing to the tube getting blocked by hydatid membrane. On the 21st the patient began to perspire freely at night, and pain with friction was again noted over the hepatic region. On the 23rd it was noticed that the swellings from which fluid had been withdrawn had quite subsided. On the 26th he had an attack of syncope, with blanched, cold surface, and very weak intermittent compressible pulse.

On Feb. 3rd he felt a chill, followed by feverishness, with temperature 102·2°. The pulse remained irregular and intermittent. The liver continued to retract, and on Feb. 7th it was noted that in the right nipple-line it reached to the umbilical level; the margin could not be defined; but on light percussion the abdomen was resonant in the line of the left rectus to two inches above the umbilicus. On the 25th some fulness was noticed between the right nipple and the median line, two inches above the level of the umbilicus.

On March 6th the fulness noticed on Feb. 25th between the right nipple and median line had much increased, and was fluctuating and tender, while a portion of this prominent area was tympanitic on percussion. Two days later the swelling was tapped, and sixteen ounces of horribly fetid, semi-purulent matter evacuated, but it was not considered advisable to withdraw all the contents. On the 10th, after consultation with Mr. Morris, it was decided freely to evacuate and to drain the cyst; ether was therefore administered, and an incision two inches and a half long was made parallel with the ribs; the abdominal walls were then carefully dissected through, bleeding vessels being secured at each step. On the cyst wall being reached it was made secure to the parietes by means of silk sutures, and was then freely opened, thirty ounces of fetid pus being let out. The cavity was well irrigated with iodine, and a large drainage-tube, seven inches long, was inserted, and the edges brought well together with sutures. The patient felt no ill effects from the operation, and from that day improvement rapidly took place, the pulse became regular, sweating at night subsided, appetite good, and the patient quickly gained flesh. The wound was dressed throughout on antiseptic principles, the tube was gradually shortened and finally removed, and on May 2nd the opening had completely healed. The patient left the hospital a few days later, quite convalescent.

In commenting on this case Dr. Powell remarked that it presented several features of interest. 1. When first admitted the multiplicity and hard crater-like feel of the tumours, presenting as yet only deeply from the surface of the liver, suggested malignant disease, a diagnosis favoured by the general aspect of the patient, although grounds for hesitation were afforded by the duration of the symptoms. 2. The smoothness and fluctuation of the tumours, as after a few weeks they came nearer the surface, rendered the change of diagnosis to that of hydatids inevitable. 3. The contraction of the tumours successively after aspiration through a fine trocar of a portion only of their contents, was an illustration of the fact first pointed out by Murchison, that death of the parasites commonly ensued upon even a partial removal of the fluid media in which they flourish, and in the majority of instances was a sufficient as well as a safe treatment. 4. The suppuration which subsequently took place in the largest tumour evidently arose from decomposition of the contents of the sac consequent upon the death of the parasite. Probably "hydatid abscess" always arose in this way. It was a question whether this occurrence might have been avoided had a smaller proportion of the

fluid in the first instance been removed from this cyst by aspiration. 5. The observations early in the case of friction over the liver was of value in affording certain evidence of adhesions being formed between the surface of the liver and the parasites, which at a later period greatly diminished the risks from incising and draining the abscess.

WOLVERHAMPTON AND STAFFORDSHIRE HOSPITAL.

CASES OF HEART DISEASE RELIEVED BY BLEEDING.

FOR the following notes we are indebted to Mr. W. Collier, M.A., M.B. Cantab., late house physician.

CASE 1. (Under the care of Dr. Millington.) — Mrs. A. P——, aged forty-two, was admitted on Aug. 14th, 1883. Six months previous to admission she had got wet through, the exposure being followed in a few days by severe pain across the loins and over the cardiac region, with slight dyspnœa and swelling of the legs and ankles. These symptoms had gradually increased in severity; for the past eight weeks the urine had been scanty. Condition on admission: Temperature 98·4°; urgent dyspnœa; intense cyanosis of lips and face; jugularis greatly distended, with marked pulsation of the carotids; pulse almost imperceptible; respiration 46; great œdema of legs and ankles, some ascites; urine one-third albumen; spoke with the greatest difficulty. Heart: Apex-beat displaced downwards and to the left; area of dulness much increased, especially laterally, and sounds muffled, systolic bruit culminating at apex. Lungs: Over the lower two-thirds of the right lung the percussion note was dull, with increase of vocal resonance and tactile fremitus; a few small crepitations heard over same area. Ordered ten minims of tincture of digitalis with five grains of carbonate of ammonia, to be taken every five hours. To have four ounces of gin daily. On Aug. 16th, shortly after midnight, about thirty-eight hours after admission, as the condition was extremely critical, and as there had been little or no improvement, she was bled from the right arm to the extent of about four ounces, which was almost immediately followed by an improvement in the breathing, and the patient expressed herself as feeling more comfortable. On the following morning a further improvement in the breathing was noticed, and the cyanosis was greatly diminished. On the 18th the amount of urine passed was greatly increased. On the 21st the pulse was 90, small and irregular; respiration 38; percussion note over the right lung more resonant; respiratory sounds clearer, and small crepitation less abundant; general condition greatly improved.—September 3rd: Continues to improve; albumen much diminished; heart sounds loud and irregular; mitral bruit can no longer be heard.—18th: Has been getting up for past day or two; œdema of legs has quite disappeared; ordered sulphate of iron pill three times a day, and a draught of quinine and digitalis three times a day.—24th: Discharged convalescent.

CASE 2. (Under the care of Dr. Totherick.)—Mrs. E. T——, aged fifty, was admitted on Nov. 27th, 1883. For the past eighteen months she had been troubled with shortness of breath on exertion, and attacks of cardiac pain and palpitation. During the past few weeks these symptoms have increased much in severity. At the age of nineteen she had a severe attack of rheumatic fever. Condition on admission: Considerable dyspnœa; anxious expression; lips and face somewhat cyanosed; veins of neck congested. Respiration 38; pulse small and weak (120). Heart: Apex beat diffused, displaced downwards and to the left; area of dulness much increased both in vertical and lateral directions; sound rapid and muffled; short systolic bruit heard over mitral region. Lungs: Physical signs show considerable congestion of both bases. Liver: Area of hepatic dulness much increased, about six inches and a half, in the nipple-line. Urine showed a trace of albumen. A draught of infusion of digitalis, carbonate of ammonia, and spirit of chloroform was ordered, to be repeated every six hours.—Nov. 30th: Dyspnœa diminished and general condition improved.—Dec. 1st: Dyspnœa this morning much increased; lips and face again cyanosed.—12 o'clock (night): Breathing worse than this morning; respiration 52, gasping; cyanosis increased; veins of neck considerably distended. Bled immediately from the right arm; about four ounces drawn off. Pulse at once improved. On the following morning the patient expressed herself as feeling very much better; had had a good sleep during the night. Dyspnœa much less marked. Respiration 36; pulse 104, decidedly stronger. On Dec. 6th the patient left the hospital greatly benefited.

CASE 3. (Under the care of Dr. Totherick.) — Charles L——, aged thirty-three, was admitted on Oct. 25th, 1883. This illness commenced about a month before admission with shortness of breath, followed in a few days by pain and palpitation of the heart, and swelling of the legs and feet. His previous health was very good; he has worked hard at well-digging. Condition on admission: Marked dyspnœa and cyanosis, orthopnœa, œdema of legs and feet. Pulse small and very irregular. Urine contains slight trace of albumen. Ordered tincture of digitalis and carbonate of ammonia, to be taken every six hours.—27th: Dyspnœa increased. For the past two days has been coughing up a quantity of bright aerated blood; pericardial friction present; soft double bruit heard at apex.—30th, 3 A.M.: Breathing much worse; still coughing up bright-coloured blood. Bled from the left brachio-cephalic vein to about eight ounces. No immediate relief in symptoms noted. 11 A.M.: Decided improvement now observed. Heart sounds louder and clearer. Pulse slower and more marked (112); dyspnœa diminished. Patient continued to improve, and left the hospital on Nov. 16th much relieved. Continued free from dyspnœa and other symptoms for three weeks, when he recommenced work, at sheet-iron rolling; in a fortnight all the previous symptoms had returned.—Jan. 5th, 1884: Readmitted to hospital; heart sounds very muffled and irregular; systolic bruit present at apex. The symptoms were for a time much relieved by taking one minim of the 1 in 100 solution of nitro-glycerine every two hours during the day, with digitalis and spirit of sulphate of ether at longer intervals.—14th: Became much worse; signs of fluid present at both bases.—19th: Died. Autopsy showed dilatation and some hypertrophy of the cardiac cavities, with pericardium closely adherent throughout.

Remarks by Mr. COLLIER.—It will be noticed that in the cases here reported the cardiac tonics and stimulants used—digitalis, ether, and ammonia, &c.—had during their two or three days' trial failed to give relief. The chief indications for bleeding were the extreme distension of the right side of the heart, together with the urgency of the symptoms. Bleeding in the first two cases was followed by immediate and marked relief, which relief, as the further history shows, was of a permanent nature. In addition to the immediate benefit, the withdrawal of a few ounces of venous blood by relieving the distension of the right side of the heart seemed to bring into play for the first time the physiological action of the drugs used. In the third case, although the benefit was not so marked as in the other two, it was sufficient to encourage one to adopt the same treatment under similar circumstances.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Composite Temperature Chart of Small-pox.—Gangrene of the Lung treated by Drainage, with Recovery.—Basic Cavities of the Lung treated by Paracentesis and Free Drainage.

AT the penultimate meeting of this Society, held on Tuesday last, Dr. George Johnson, F.R.S., President, in the chair, a lively interest was aroused by the reading and discussion of papers dealing with the subject of pulmonary surgery.

Dr. ERNEST HERMAN read a paper on an Average or "Composite" Temperature Chart of Small-pox. The charts described in this paper were constructed from observations made during the small-pox epidemic of 1871, in a temporary hospital at Shoreditch. These charts are made up by adding together the figures indicating the temperatures in the different cases for the same period of the day, and dividing the total by the number of observations. By this method the average temperature of all the patients is shown from day to day, instead of that of each individual patient, as is the case in ordinary temperature charts.

Dr. CAYLEY read a paper in conjunction with Mr. PEARCE GOULD on Gangrene of the Lung treated by Drainage, with Recovery. The patient was a girl aged twelve, who was

admitted into the Middlesex Hospital on Jan. 18th. Four years ago she had had scarlet fever, which was followed by otorrhœa. On admission there was an acute abscess over the mastoid process on the left side, and extensive denudation of the bone about the external auditory meatus. The abscess was opened, and Mr. Gould, after trephining the mastoid process, gouged away some soft necrosed bone from the interior of the temporal bone. The patient progressed favourably till Jan. 28th, when symptoms of pyæmia developed. She had repeated rigors, with high fever of a strongly remittent type. On Feb. 2nd signs of pleurisy with consolidation at the base of the right lung appeared. On the 7th her breath became offensive, and she began to spit up small quantities of stinking pus. On the 16th, these symptoms having continued, and the child having become extremely emaciated and prostrate, it was decided to drain the gangrenous cavity. There was now dulness over the right base as high as the angle of the scapula, and at one point some bubbling crepitation. Mr. Gould accordingly punctured the lung with a large-sized trocar and cannula, and introduced through the latter a drainage-tube. Stinking pus and a sequestrum of gangrenous lung were discharged through the tube. The child rapidly improved, and was discharged on March 27th.

Dr. CECIL Y. BISS read a paper on the Treatment of Pus-secreting Basic Cavities of the Lung by the Method of Paracentesis and Free Drainage. The author groups pus-secreting basic lung cavities under three heads: (1) Those in which paracentesis is imperatively called for; (2) those in which it is unjustifiable; and (3) those in which it is a question of special difficulty whether it should be performed or not. A case was then related illustrative of the last group. A man aged thirty-two, with a satisfactory family history, and who had not suffered from any previous pulmonary disease, had been affected with cough and profuse expectoration for six months. On admission to hospital he presented at the right posterior base dulness, reaching as far as the spine of the scapula, with absence of breath-sounds and vocal fremitus. The heart's apex beat was half an inch outside the nipple-line. The case was regarded as one of abscess at the base of the lung, with slight effusion into the adjacent pleura. An exploratory puncture failed, however, to detect any fluid. Soon afterwards obscure friction sounds developed over the dull area, and then loud cavernous respiration with intensified voice sounds, the pyrexia and hectic symptoms becoming more marked. About a fortnight later —medicinal means having failed to give relief—a second exploratory puncture was made, with negative results, except that the lung was judged to be adherent. The course of the case continuing unsatisfactory paracentesis was resolved on. Professor Marshall made an incision two inches long along the tenth intercostal space, over the point of maximum intensity of the cavernous sounds, reaching and exposing the pleura; a trocar was then gradually inserted to a depth of four inches, when a cavity was entered, from which whiffs of fetid air were expelled, and a scanty blood-stained discharge flowed. The wound and cavity were temporarily plugged to stanch hæmorrhage, and next day a drainage-tube was inserted, through which a puriform discharge began freely to escape. The symptoms were considerably, but not wholly, relieved. Ten days later signs of cerebral abscess appeared, and in another ten days the patient sank. The autopsy revealed a number of bronchiectatic cavities in the right lung, one of the largest of which had been pierced and drained by the operation. The lung was invaded by fibroid change, and much contracted. Two abscesses had formed in the brain. The opposite lung and all the other organs were healthy. No miliary tubercle was perceived anywhere. The following diagnostic points were briefly discussed:—(1) The brief history of disease in comparison with the apparently long-standing morbid conditions; (2) the displacement of the cardiac apex; (3) the remarkable alterations which took place, during the course of the case, in the auscultatory signs; (4) the invariable absence of tubercle bacilli from the sputa, and the inspissated secretions found after death in the lung cavities. In conclusion, the drawbacks and advantages of paracentesis of pulmonary cavities (apart from phthisis) were discussed, and a brief recapitulation of some of the literature of the subject was given.—Mr. GODLEE spoke of some of the difficulties with which the surgeon had to contend: first, those of the exact diagnosis of a cavity; and, secondly, the difficulty of ascertaining whether or not the pleura was adherent. Reference was made to cases which illustrated the two difficulties. A case of a child with two large cavities in the chest was referred to in which the pleura appeared to be adherent. With exploring needles some pus was obtained from the upper cavity. Excision of a portion of the fourth rib proved that adhesions were almost wholly wanting. Antiseptic precautions had been followed out. After some days a further operation was resorted to, but without any cavity being detected. Another case of a man under the care of Dr. Bastian at University Hospital, who seemed to have suffered from pleuro-pneumonia, was mentioned. An exploring needle was used, and after some trouble pus was discovered. However, here it was thought advisable to excise a portion of the rib, and then an irregular pulmonary cavity was tapped and freely drained. The man rapidly improved. With regard to instruments, a large cannula with a blunt point, as used by Sir Joseph Fayrer in hepatic abscesses, was recommended; and a long trocar with a cannula made of celluloid was shown; the celluloid tube might be made use of as a drainage-tube, being left in after being used as a cannula.—Dr. KINGSTON FOWLER spoke of the case of a man aged forty-seven, of healthy family, who had seemingly taken into his air-passages a second left lower molar, which caused great dyspnœa, and failed to be ejected by emesis and inversion of the patient. When first seen there was expectoration of a considerable quantity of frothy mucus, as much as half a pint in the twenty-four hours. Emaciation was marked, and night sweats had set in. At the right base the vocal fremitus was diminished, there was marked dulness, some friction was heard in the mid-axilla, and the physical signs indicated the presence of a cavity at the right base behind. An operation was performed, with strict antiseptic precautions, by Mr. Marshall; a trocar and cannula were passed in, and an incision made down and outwards for an inch; some thick sanious matter was let out, and a cavity was detected, which was probably an enlarged bronchus. The cavity was packed with strips of carbolised gauze, and after some days these were replaced by a drainage-tube. Later on he brought up eight ounces of muco-purulent sputum, and seemed slowly to improve. The drainage-tube was gradually shortened, and the wound ultimately nearly healed. There was still evidence, however, of a small cavity at the right base below the angle of the scapula. No evidence of disease elsewhere in the lungs was to be detected, and tubercle bacilli had not been found in any of the sputum examined.—Mr. WALSHAM related the case of a patient who had a phthisical cavity at the left apex; a small sinus appeared above the left nipple. The speaker followed the sinus upwards to the second intercostal space, laid open the cavity, and washed it out with a solution of carbolic acid. A slow but great improvement took place, increase of flesh was made, and the strength was wonderfully improved.—Dr. BROADBENT related the case of an officer who was the subject of a basic cavity. He had previously suffered from some lung mischief. There were evidences of a very large cavity at the base of the left lung; emaciation, night sweats, and fever were slowly reducing the patient's strength. Mr. Edmund Owen was called in to lay the cavity freely open, with the result that some improvement took place. A second operation was thought to be necessary, but the physical signs rendered this unadvisable. A further flow of pus took place, and the patient seemed to be doing well, when he started off without permission to the south of France, where he subsequently died. Although the result of Dr. Biss's case was unfortunate, he was of opinion that as a pioneer in this new field of surgery the paper was of great importance.—Dr. DOUGLAS POWELL thought that the two papers which had been read illustrated the two classes of cases in which operative interference with the lung was properly called for. He considered that if a patient with bronchiectasis was slowly going to the bad from its effects there was nothing better to be done than to operate; operation drained away the residuum which the patient was unable to expectorate. In Dr. Cayley's case it was obvious that the cavity contained a "sequestrum of lung" and was a typical one for operation. Dr. Biss's case was probably one of fibrosis of the lung originating either in a chronic pneumonia or pleurisy and leading on to a "loculated cavitation" of the lung. The patient was suffering so severely from the fetid fermentation that surgery was decidedly called for. He regarded the absence of tubular or cavernous breathing as conclusive against the existence of a large cavity, but we might have many bronchiectatic spaces without such signs. No doubt these cavities opened into one another after a time, and so led to the seemingly sudden development of a large cavity with its accompanying phy-

sical signs. It was worth while to consider whether by passing a drainage-tube we might not create a centre of relief, round which cicatricial changes might take place greatly to the advantage of the patient by inducing healthy cicatrisation of the rest of the diseased tissue. He said, in answer to Mr. Godlee's remarks, the physical signs of adhesion to the lung to the chest wall were practically *nil*; retraction of the intercostal spaces was insufficient to diagnose that condition.—Dr. BERNARD O'CONNOR asked Dr. Biss what were the signs of bronchiectasis, and whether alcohol had anything to do with the pulmonary condition.—Dr. CAYLEY, in reply, said that he thought it was safer to thrust a large-sized cannula into the lung, rather than make a free incision. He considered that the operation was quite acquitted of having anything to do with the abscess of the brain in Dr. Biss' case.—Mr. PEARCE GOULD, in reply, said he was to be considered fortunate in having struck the cavity the first time, for on introducing a second trocar by the side of the first he failed to reach the cavity; in this respect he concurred with Mr. Godlee's remarks. Richter had foretold that surgical aid would be employed for abscesses of the lung, and that only in cases which were not tubercular and the general constitutional state of the patient not far undermined. It was extremely desirable that the two layers of the pleura should be adherent, but Krönlein had recently removed a sarcomatous tumour growing from the sixth left rib, and made a free opening into the pleural sac, and although there was severe dyspnœa at the time, and a tumour as large as a walnut was excised from the lung, the patient made a complete recovery. It was perhaps not a matter of vital importance whether the pleural surfaces were adherent.—Dr. BISS, in reply, considered that the diagnosis of the exact situation of the cavity had a parallel case in abscesses of the liver. Paracentesis of the lung was perhaps not so simple an operation as might have been concluded. Mr. Godlee had narrated a case in which the physical signs conclusively showed the existence of cavities. Extremely fine trocars only had been used, and there were many conditions which might explain the want of surgical success in finding the cavities. In answer to Dr. Broadbent, he thought that the patient must have died whether operated upon or not, though no doubt death was accelerated by surgical interference. Further, three cases of bronchiectasis had been narrated, in which cerebral abscesses had appeared, and in one of these no operation had been performed. He did not think Dr. O'Connor's question a practical one, as operation ought to be performed whatever the nature of the basic cavity. Alcohol had nothing to do with the case in question.

CLINICAL SOCIETY OF LONDON.

Pyelo-lithotomy.—Aortic Aneurism.—Hernie-en-bissac.—Impaction of Bone in Larynx.

THE last meeting of the session of this Society was held on May 23rd, Sir Andrew Clark, Bart., President, in the chair. There was a singular absence of discussion on the papers read. It was announced that a more public display of the living specimens would be attempted when the Society met next session.

Mr. WILLIAM ANDERSON read notes of a case of Pyelo-lithotomy. The patient, a joiner, aged twenty, was first seen in July, 1883. For nine months he had suffered from attacks of lumbar pain and hæmaturia, brought on by physical exertion. The urine was always free from pus and calculous matter. On admission nothing could be detected on physical examination of the bladder or renal region. The urine contained blood-corpuscles and crystals of uric acid. At the end of August pain and tenderness were felt in the left loin, and a local fulness accompanied an increase in the area of renal dulness. An operation was performed on September 10th. The kidney was exposed under complete antiseptic precautions by an oblique incision parallel to and about two inches below the eleventh rib. A stone was detected in the pelvis both by digital exploration and acupuncture, and was reached by an incision through the wall of the duct without encroachment upon the renal parenchyma. It was seized with a pair of forceps, but was, however, so firmly fixed that the dislodgment could only be effected by leverage with the finger, by which means it was extracted. There was practically no hæmorrhage after the completion of the parietal incision. Some urine appeared to have escaped through the wound during the first twelve or eighteen hours, after which the whole passed by the normal channel. The secretions at first contained a free admixture of blood and leucocytes, but improved in character day by day. The temperature rose to its highest point, 102·2°, on the second day, and sank permanently to the normal level after the tenth day. The discharges from the wound remained aseptic throughout. On the seventh day the drainage-tube was removed, and the antiseptics were abandoned at the close of the second week. About five weeks after the operation there was but a superficial sore at the site of the wound, and the patient was able to walk about the ward without pain. The urine presented only a trace of albumen and a few cellular forms. The calculus weighed sixty grains when entire, and consisted mainly of calcium oxalate, with about ten per cent. of uric acid and traces of magnesium phosphate. In shape it resembled a large molar tooth with a rough crown and two fang-like processes. At the end of two months the patient was attacked by pain in the left renal region followed by the expulsion of a small stone by the urethra. Since then nearly forty calculi have been expelled. Excluding from present consideration all cases of nephro-lithotomy complicated by the presence of a lumbar sinus, or in which an abscess has been previously opened (as in Mr. Morrant Baker's case in 1874), this example may be enumerated as the eighth on record. The operations have been completely successful in seven, and followed by a fatal result within twenty-four hours in one, in which the kidney on the affected side was the seat of abscess and the opposite organ was extensively diseased. In no instance did any permanent fistula result, the urine ceasing to drain through the wound after the lapse of an interval ranging from eighteen hours to eighty-one days. The operative procedure differed principally in the treatment of the kidney. In five cases the stone was reached by division of the healthy renal tissues, and in two was removed through an aperture made in the duct. The term of pyelo-lithotomy was proposed as a name for the operation now described, to distinguish it from the procedure in which the stone is extracted through a renal incision, and to which the name nephro-lithotomy more properly belongs. As incidental points for notice in the present case may be mentioned: first, the deceptive fulness and tenderness of loin observed before the operation, a sign which led to a suspicion of enlargement of the kidney, but was probably attributable to distension of the descending colon; secondly, the shortness or absence of the twelfth rib, the lowest palpable rib being the eleventh, a peculiarity to which attention has already been drawn, and one which, if undetected, might bring the pleural sac into danger during the incision through the parietes.—Mr. RICKMAN GODLEE could not altogether think that if renewed operation were necessary, it would be well to remove the kidney, since one could not be certain that the other kidney was perfectly sound. As to the danger from incising the renal parenchyma, in his own experience he had found that the bleeding ceased almost immediately. If the pelvis were chosen, it could only be got at from the front or behind, and so might necessitate a deeper incision. He mentioned a case in which there had been a large amount of calculus (seven drachms), and in which he tore the structures of the organ through with his finger without producing any serious symptoms.—Sir ANDREW CLARK said it was plain that some defect in diet or vice of nutrition was at work in the causation of the disease.—Mr. HENRY MORRIS thought the time had hardly yet arrived to determine through what part of the kidney it were best to operate. He thought the stone would more naturally present itself through the renal substance where the disease was marked. The multiplication of names was not to be recommended. He considered that hæmorrhage from the renal substance was very readily stopped by means of elastic compression. If the stone be exposed by the finger nail, the risk was rendered still less. The finger served the same purpose as the sponge in restraining hæmorrhage. He was not yet convinced that the preference was on the side of operating through the pelvis. He was disposed to think that a free incision into the kidney was permissible when the clinical signs of calculus were unequivocal, and were exploration had failed to detect the stone. A case was narrated in which nephrectomy was performed because exploration failed to find the calculus. Before nephrectomy was finally resorted to it was regarded as important to explore the bladder, certainly in the female, and probably in the male, with a view to make out the state of the lower

end of the ureters. The value of this was illustrated by a case in which a female patient actually had a calculus in the lower end of one ureter, which was felt by exploring the bladder, though the patient was too ill for further operation.—Mr. WILLIAM ANDERSON, in reply, said there was nothing to point to the cause of the disease. The calculi passed were accompanied by pain and other signs, always on the left side, thus negativing the notion that some of the calculi came from the right kidney.

Mr. RICKMAN GODLEE read for Dr. FINLAY notes of the sequel of a case of Aortic Aneurism. The case was first brought forward at a meeting of the Society on Feb. 10th, 1882. A full report appears in the Transactions, vol. xv., p. 151. She presented well-marked signs of a sacculated aneurism of first part of the aorta, with aortic and mitral incompetence, and had been treated for six months in the Middlesex Hospital on Mr. Tufnell's plan of restricted diet in the recumbent position, with increasing doses of iodide of potassium. For two years and a half subsequently she had attended as an out-patient, having taken almost continuously iodide of potassium in considerable doses. The question proposed for discussion when the patient was shown was the propriety or otherwise of operative treatment by electrolysis, or the distal ligature, the arguments for and against which were stated in the paper then read. As independently of other considerations, she was unwilling to be again laid up in the hospital, it was resolved merely to continue the treatment with iodide of potassium, and she attended regularly at the out-patient department once a fortnight, until her death, which took place on March 26th, 1884. On the last occasion on which she was examined—viz., on January 18th, 1884, she stated that she felt better in her general health than she had done when first shown at the Society's meeting in 1882. As to her physical condition the notes then made were practically the same as those read on the former occasion. On March 22nd, however, she was seized with shortness of breath, cough, and pain in the chest, and she died on the 26th with symptoms of bronchitis and congestion of the base of the left lung. At the post-mortem examination the aneurism was found to be adherent to the cartilages of the second, third, and fourth ribs on the right side, and to the adjacent part of the sternum. The sac, which was divided into two parts by a calcareous ridge, sprang from the aorta immediately above the aortic valve, and contained some loose, soft, decolourised clot. It was roughened and thickened by patches of atheroma, which had proceeded in many parts to calcification. Parts of the sternum and of the cartilages of the third and fourth ribs were eroded. The cusps of the aortic valve were thickened, puckered, adherent, and obviously incompetent. The muscular substance of the heart was pale and soft, and under the microscope showed advanced granular degeneration. The lungs were œdematous, and the base of the left lung was congested and pliable, breaking down under pressure with the finger. The condition of the aortic valve established the fact of the aortic regurgitation, regarding which doubts had been expressed when the patient was shown. As to the effect of treatment, there was no deposit of fibrin or consolidation of the sac. Probably all the methods of treatment used acted in the same way by lowering the blood pressure. It was worthy of note that the aneurism was not directly the cause of death, which was due rather to the degeneration of the heart's substance, consequent upon the incompetence of the aortic valve.

Mr. GOLDING-BIRD read a paper on two cases of Hernie-en-bissac in Women, one being Intra-parietal. The first was a woman, aged forty-seven, on whom he had operated in 1878 for right femoral hernia, opening the sac and removing the omentum. In Dec. 1880, he again operated for fresh strangulation, and then found the peculiar condition described, but of which there is no mention in the notes of the first operation; presumably, therefore, it had developed subsequently. Now, besides the usual and large hernial sac there was, leaving it at right angles, a process of sac just the size and shape of the finger (thumb) of a glove, and passing down into the right labium. It left the parent sac just below the pubic spine. The main sac was, at the close of the operation, dissected up and removed, being ligatured at its neck, but the labial portion, being firmly attached, was cut off and left *in situ*. There appeared to be every prospect of a radical cure resulting. Though strictly the term *en bissac* was applicable only to inguinal hernia, yet he had employed it here, so exactly did this hernia agree with the requirements for that condition save in regard to its position in the thigh. The other case was that of a woman, aged sixty, with twenty years' history of left inguinal hernia. After wearing a truss the first ten years it disappeared until two years ago, when, in addition to the inguinal protrusion, there developed a large and subcutaneous tumour, lying above Poupart's ligament and between the crest of the ilium and the external abdominal ring. Twice it had appeared, and then in a few days nearly subsided, but failed to do so on a third occasion, the beginning of this year. Kelotomy was performed, and it was then found that whilst the original hernial protrusion existed at the external ring, a large and laterally connected sac had burst through the front part of the inguinal canal, leaving only a broad external pillar, and lay in the aponeurosis of the external oblique. The bowel was relieved, after division of the internal ring, without opening the sac; this was then opened and much inflamed omentum removed. The patient sank from exhaustion on the third day. Mr. Golding-Bird referred to a case of Mr. Luke's, published thirty years ago, almost identical with his own; but the great peculiarity of this case he considered to be in the double sac; the absence of taxis or any violence ever having been employed to induce its formation; its bursting through the external oblique fibres in front of the canal, and its subcutaneous position, that of intra-parietal herniæ being always inter- or sub-muscular.

Dr. F. TAYLOR read notes of a case of Impaction of a Bone in the Larynx, contributed by himself and Mr. GOLDING-BIRD. A man aged sixty-three came under treatment for a cough which he had had more than five months. Though he did not complain of his throat, a slight stridor led to an examination of the larynx, when a foreign body resembling bone was seen lying below the cords, and extending from front to back of the larynx. It appeared to be about a quarter of an inch broad, but there was breathing space on either side of it, and on phonation the cords closed easily over it. On being questioned he remembered that four months previously he had taken some sheep's-head broth, and had swallowed with it a piece of bone. This stuck in the back of his throat, and he was unable to move it with his fingers; but his wife with a tablespoon pushed the bone down his throat, and he thought it was safely disposed of. For a week his throat was sore, and for two or three days he spat some blood, but since then he had not had any inconvenience from it. He was admitted into the hospital, and was found to have the physical signs of emphysema, with expectoration of much frothy mucus, and metallic cough, preceded by stridulous inspiration. After a few days he was transferred to a surgical ward, and Mr. Golding-Bird proceeded to remove the bone by laryngotomy. On dividing horizontally the crico-thyroid membrane and putting in a tracheal dilator the bone was at once seen, and removed with Toynbee's ear forceps. A second smaller piece, the size of a pea, was seen impacted in the mucous membrane covering the cricoid, and also removed. The patient made a rapid recovery, and when seen again, two years later, the larynx appeared normal; the cords moved freely, but were slightly pinker than usual. The larger piece of bone removed measured three-quarters of an inch in length, five-eighths of an inch broad, and a quarter of an inch thick. Attention was called to the large size of the foreign body, the curious way in which it became impacted, its long retention without inconvenience to, and, indeed, without the knowledge of, the patient. Its large size, and the apparently firm impaction below the cords led to the adoption of the external operation rather than its removal by the mouth.—Dr. DE HAVILLAND HALL inquired whether any attempt had been made to remove the foreign body by means of a pair of laryngeal forceps.—Dr. COUPLAND gave an account of some cases of Impaction of Foreign Bodies in the Air-passages. One was a woman, who had caries of the base of the skull, and died suddenly in a state of asphyxia, which proved to have been due to the falling into the glottis of a piece of necrosed bone from the base of the skull. Another case was that of a boy who first came under treatment for symptoms of chest disease, which was diagnosed as pleurisy at the right base. Later on the signs of consolidation manifested themselves at the same site. It appeared from the history that he had been drinking some mutton broth and suddenly choked whilst so doing. It was not suspected what the cause of the lung mischief was until the boy expectorated from his lung a piece of mutton bone. After this the signs of pulmonary disease cleared up, and he left the hospital perfectly well.—Mr. GOLDING BIRD said that the forceps were not used because the bone was broadside on

and much below the level of the glottis. He did not think the operation through the crico-thyroid membrane was specially dangerous.—Dr. FRED. TAYLOR, in reply, thought laryngotomy was much preferable, since it also removed the smaller piece of bone, which might otherwise have gone further down the air-passages.

The following living and card specimens were shown :—Mr. Howard Marsh : (1) Knee Clamp for the Treatment of Dislocated Internal Semilunar Cartilage ; (2) A case of Strangulated Inguinal Hernia, in which the intestine was opened and stitched to the sac, the operon was subsequently destroyed by Dupuytren's enterotome, and the intestine was closed and returned into the abdominal cavity ; (3) Removal of Dislocated Astragalus. Dr. Dyce Duckworth : A Drawing and Photograph of a case of Myxœdema. Mr. Bernard Roth : An unusual case of Spinal Lateral Curvature, chiefly of the cervical region, with extreme osseous deformity.

EPIDEMIOLOGICAL SOCIETY.

AT the meeting of this Society, held on the 14th inst., Dr. Norman Chevers, President, in the chair,

Dr. JOSEPH EWART read a paper on the Colonisation of the Sub-Himalayas, with Remarks on the Management of European Children in India. In the sanitary and ethnological history of the plains of British India there is one fact which stands forth with conspicuous prominence—viz., the absolute powerlessness of Europeans to thrive and continue their race through many successive generations. Twining declared that there was no known instance in his time of a pure European descent in the country extending beyond the third remove, and Sir Joseph Fayrer's observation prolongs it to the fourth generation only, and no further. Although the effects of climate can be much mitigated by hygiene and sanitation for adults and children, anything like colonisation such as we have seen and now see going on in other lands, is totally impracticable. This truth is noted in the degeneracy of our race wherever it has been attempted in the plains. Hence the wisdom of frequent change to the hills or Europe or both for adults, and early transfer of children to England for physical training and intellectual education. Hence also the necessity for frequent change of the European troops to this country, for although the effects of prolonged residence may be alleviated by increasing knowledge of the means to be used to withstand the climate and its ailments, there is no such thing as real or substantial acclimatisation for the European. But is it so in those hill climates sufficiently elevated to be free from the generation of malaria, and temperate enough to render out-door labour on the part of the European tolerably healthy and pleasant? The evidence in favour consists in the advantages which are derived by adults who periodically visit the hills, and in most who are not the subjects of visceral disease, these are signal and decisive, and by children who, if kept long enough there, are immensely benefited. Moreover, the experience of the results of residence of the children at the Lawrence Asylums at Ootacamund, Abu, Sanawar, and Murree are not really unfavourable. Hitherto the hills have been mainly used for temporary resort to preserve health or overcome the ills and enervating effects of residence in the comparatively unhealthy and malarious provinces of the plains, and in a few cases by retired officers. As far as a judgment can be formed from the temperate character of their climates, their freedom from malaria and epidemics, their marked beneficial influence in preserving the health of European men, women, and children, and in contributing to its restoration in those suffering from functional disorders of climatic origin, the inference is that if undertaken in suitable places, the colonisation of the hills is probably not impracticable. The second division of the paper is devoted to a practical review of the best means for the management of infants and young children in India. That most of the high mortality is preventable is clearly demonstrated. But when all that science and art can do, it is painful to note, even among the children of the well-to-do in the plains, notwithstanding the advantages of an open-air life—for they are reared in roomy mansions, always pervaded by constant relays of fresh air—the best nursing and medical care, and immunity from several of the infantile maladies so fatal in temperate climates, that they seldom present the all-round physiological tone, physical robustness, muscular rotundity, hardness, plumpness and rosy complexions of children similarly circumstanced in this country. For all who can afford it, children should not be kept in the plains beyond the fifth or sixth year. A question of some moment is often presented for solution. Should European children born in England be taken to India? If suckling they may be for a time, but it would be better to have the process completed at home, and then to leave them here under proper custody, unless provision can be made for their passing the hot, rainy, and autumnal seasons, or what is still better, the whole of the ante-educational period of childhood in the hills.—In the discussion which followed, the President, Surgeon-General Murray, Drs. Cullimore, Moore, Mair, Pringle, and White, and Mr. Long took part.

ACADEMY OF MEDICINE IN IRELAND.

A MEETING of the Medical Section was held on Friday, March 14th.

Dr. WALLACE BEATTY read a paper describing two cases affected with a Peculiar Form of Skin Disease resembling in some of its features urticaria pigmentosa. The patients were two brothers, aged respectively fifteen and twelve years. The disease first appeared at the age of twelve in the elder brother's case, and at the age of eleven in the younger. The course of the affection appeared to be as follows :—An itchy spot manifests itself without any appearance of eruption. The patient scratches it. Redness is seen, and sometimes, according to the elder brother's statement, an appearance like hives. This subsides, and in a few hours a slight raised pimple is observed, pin-head size, or a little larger. This soon flattens, enlarges, and becomes dull brown pigmented, forming a circular spot about three-eighths of an inch in diameter, presenting to the finger passed over it either the feel of normal skin, or of skin rather tougher than normal. This pigmented skin spot is unaltered by pressure. In a short time the centre becomes whitish, the pimpling remaining brown, and, finally, the brown colour disappears, leaving white spots of different sizes, some very small, others large, but the greater number smaller than the brown macules. Some of these white spots are on a level with the surface of the skin and firm to the touch, while others present minute depressions, somewhat thimbled, or minute grooves radiating from the centre, appearing like scars. All these varieties, pimples, brown macules, macules with a brown pimpling and whitish centre and white spots, are present on various parts of the body, the front and back of the chest being most affected. A mottled appearance is thus produced, which is specially evident on the back. The abdomen and genitals are unaffected. The face and the flexor aspect of the limbs are but slightly affected. Dr. Beatty could not develop factitious wheals. There is no reason to suspect syphilitic taint. The disease, while it resembles urticaria pigmentosa in the presence of some itchiness, wheals produced by scratching, and subsequent pigmentary changes, is distinguished from all the cases of that disease formerly described in the following points :—1. The disease commenced several years after birth. 2. The spots are at first chiefly papular, and rapidly flatten ; they are not, as in most cases of urticaria pigmentosa, in the form of tubercles or nodules and localised infiltrations. 3. The final stage, the formation of white spots, is peculiar.—Dr. WALTER SMITH said there could be no question that the disease described was one of great rarity, and of considerable practical importance, on account of the possibility of confounding it in younger patients with erysipelas, and in the older with stains left by secondary rash. He saw both boys some weeks ago, and was struck by the peculiar features of the disease as described by Dr. Beatty—the trophic changes and the production of scars without any vesication, pustulation, or breach of surface. It was not easy to give the disease a name other than that mentioned by Dr. Beatty—urticaria pigmentosa. Of the ordinary form of urticaria the usual features were suddenness of onset and rapid evanescence. The eruption here began early in life, persisted for months and years, and went through cycles of aggravation and decline, and in these respects presented marked features of contrast with ordinary urticaria. It was a question whether it should be put under the same heading at all. Anyone who looked at the picture of Mr. W. Morrant Baker's cases in the Clinical Society's Transactions would say the eruption approximated nearer to Dr.

Beatty's case than the illustration in Dr. Tilbury Fox's Atlas. Dr. Beatty had laid stress on the difference observed in his own case as compared with those already recorded. As there had been only nineteen cases recorded, the natural history of the disease, if it had any, was not exhausted; and therefore it was obvious that Dr. Beatty might have an opportunity of recording features in the disease hitherto not met with by other observers. As to what could be done for patients suffering from the disease, there was little to be said beyond the fact that they must be content to await the will of the great Healer of all diseases.—Dr. FINNEY said it was usual to find pigmentation following a great many eruptive diseases. There was a red or blood spot where there had been scratching, and it was quite possible the rash of the itching spot might be pruritus, but there were also spots on the back. The case was a great puzzle, and the chief point of interest was the importance of distinguishing it from the congenital and acquired forms of specific disease.—Dr. BEATTY, in reply, pointed out that the spots developed spontaneously, and that, at all events, it was obvious all of them could not have been produced by artificial scratches.

Dr. MACSWINEY reported the particulars of a case of Temporary Spinal Paralysis in a boy, aged six years, and exhibited the patient quite recovered. The boy had whooping-cough for three months. After this he was exposed to rain and cold for hours on an outside car and got an attack of tonsillitis. This was treated with local application of caustic solution, and was cured in a week. About this time also he commenced to cut four permanent molar teeth, which caused much pain. Now it began to be noticed that he was unsteady on his legs in walking. This feebleness of gait increased rapidly, extending upwards through the trunk to the arms. The muscular feebleness became daily worse, and finally, in a very short time, he was universally and completely paralysed. He could not stand; was not able to use his hands to bring food to his mouth, and had to be fed; lay in bed quite helpless, and was lifted out and in as occasion required. All this time his general health was good. He ate and slept well; looked healthy and intelligent; his muscles were not in the least atrophied; his voice was natural; he protruded his tongue in mid-line; his sphincters were unaffected; he had no fever. The electrical contractility of his muscles was unimpaired. The sole of the foot reflex was present. The patellar tendon reflex could not be demonstrated. Regarding this latter, Dr. MacSwiney found experimentally that it was not manifested in several young boys, and he raised the question, Was it present in such subjects at all? Mobility rapidly returned to the muscles, and in three weeks' time he was as well as ever. The case closely resembled Landry's disease in all important particulars. There was motor paralysis spreading rapidly from below upwards unaccompanied by fever, not involving sensibility, the bladder or the rectum, without atrophy or change in the electrical excitability of the muscles. There were also the salient points of paralysis acuta ascendens. As to its etiology, it was not anæmia of the antero-lateral columns of the cord from exhaustion consequent on the pertussis; his good condition and health were inconsistent with this. It was not the result of exposure to cold; this had expended itself in the attack of tonsillitis. It was not due to intestinal worms; anthelmintics brought none away. It was not chorea paralysis, in which there are clonic spasms, where the paralysis is never universal, and where the general health is always impaired. It was not diphtheritic paralysis, because this begins in the soft palate and pharynx, is incomplete, and is denoted by loss of faradaic contractility, anæsthesia, dysphagia, nasal voice, defective eye accommodation, amaurosis, accompanied with a fatuous idiotic expression of face. There remained reflex paralysis from dentition. To this Dr. MacSwiney attributed the initiation of the symptoms. He lanced the gums. Coincidently with this, the patient got better and soon became well. The series of pathological events was due, he believed, to exalted reflex irritability excited by difficult dentition, producing a dynamic lesion of the cord, unaccompanied, he assumed, by any structural alteration, and culminating in this attack of transitory spinal paralysis.—Dr. HENRY KENNEDY considered the extraordinary feature of the paralysis was its short duration. Having seen the case, he regarded it as presenting the appearance of a modification of chorea. No doubt the state of the mouth had a good deal to do with its development. He had seen very many cases where purging sufficed to cure the disease.—Dr. GUNN having observed the case from the admission of the little sufferer into hospital until he left, said he felt puzzled at first as to the prognosis, because the child was going from bad to worse and becoming completely paralysed. He would have given an opinion that the case was one of paralysis pure and simple. Dr. MacSwiney had not laid sufficient stress on the choreic symptoms which at first developed. The rapid cure was entirely owing to the removal of the exciting cause by Dr. MacSwiney having lanced the gums.—The PRESIDENT regarded Dr. MacSwiney's case as of great practical interest. It recalled a case in his own experience of a young girl, aged fifteen, who had nasal utterance and difficulty of swallowing. She became ataxic. Previously to coming under his care she had suffered from sore-throat. In some respects his case differed from Dr. MacSwiney's. There was albumen in the urine, and recovery, though perfect, was not so rapid. He held with Dr. Nixon that the sore-throat in Dr. MacSwiney's case was the beginning of the formidable lesion to which he had referred, and had the patient been twenty years older the paralysis would have been of longer duration.—Dr. MACSWINEY, in reply, said the President's case was no doubt one of true diphtheritic paralysis, but he found it utterly impossible to regard his own as due to diphtheritic affection, and there was absolutely no chorea present in any portion of the history of the case. Chorea was manifested mainly by chronic convulsions, but at no time were such convulsions present. Authorities the most eminent had placed upon record cases in which extremely well-marked ataxic paralysis was referred to dentition.

Dr. A. N. MONTGOMERY, at the request of Surgeon-Major Gore, A.M.D., read by permission of the Council a paper on the Etiology of the Common Climatic Fevers of the Kumaon Hill Ranges.—The discussion on this paper was postponed till next meeting, owing to the lateness of the hour.

Reviews and Notices of Books.

Transactions of the Epidemiological Society. New Series. Vol. II. London: David Bogue.

THE Transactions of the Epidemiological Society as now annually issued constitute an essential part of the literature which relates to matters of public health in all parts of the world. The second volume of the new series fully maintains the reputation acquired by its immediate predecessor. Its scope is wide. Health matters in our own country come in for an important share of the recorded proceedings. Dr. Norman Chevers, in his presidential address, gives an excellent account of the sanitary defects which are inherent to the site on which London and its environs stand, the paper carrying us back to the days when barbarians, Celts, Romans, and Anglo-Saxons each took some part in establishing the metropolis where it now stands. Dr. Longstaff discusses the very interesting question as to whether phthisis, bronchitis, and pneumonia are to be regarded as epidemic diseases. The paper, which is illustrated by a series of lithographed tables, does not pretend to arrive at any decision on the point, but it brings together a number of valuable statistical facts, which will certainly tend to clear away false notions and to indicate lines of future research. Small-pox and certain interesting points connected with the isolation of this disease are dealt with by Dr. E. C. Seaton and Mr. Collins. The former opens up the important question as to the influence of small-pox hospitals on the surrounding population, and he submits, as the result of his experience in Nottingham, that the circumstances elicited would not justify the application of the views expressed by Mr. Power as regards the Fulham Hospital to the history of small-pox distribution in his own town. To this paper we refer more in detail elsewhere. Mr. Collins gives an account of the use of tents as small-pox hospitals. The tents were well-constructed, they were efficiently heated by hot-water pipes, and they fully served the purposes of a temporary hospital. Passing from this

point to infectious hospitals generally, we find a paper by Mr. Gordon Smith, architect to the Local Government Board, on the principles which should be held in view in the planning and construction of such hospitals. Both that which it is desirable to ensure and that which it is important to avoid are fully dealt with, and the appended illustrations will be most useful to those whose duty it is to advise sanitary authorities in such matters. Mr. Gordon Smith lays special stress on the need for a pavilion containing isolation rooms at every sanitary hospital; he illustrates how such rooms should be designed, and fully proves the necessity which exists for them. India is also dealt with in a series of papers. The sanitary state of the British troops in Northern India has received the thoughtful attention of Surgeon-General De Renzy, C.B.; and Surgeon-General Cuningham, some of whose views are all but diametrically opposed to those of his colleague, records what he regards as certain sanitary lessons of Indian epidemics. Many of the opinions expressed by him are, however, unlikely to be freely accepted in this country. Surgeon-General Ewart brings together a mass of valuable information concerning the causes of the excessive mortality among the women and children of the European soldiers serving in India, and all who are interested in this important subject will find profit from the perusal of his paper. The Delhi and Oriental sore, a most troublesome, distressing, and disfiguring malady, which exists mainly, though not solely, in tropical climates, is the subject of a communication by Surgeon-General Murray, the paper being illustrated by a series of photographs showing typical cases of the disease. Cholera and the possibilities of its importation into this country formed the subject of a memorandum which was communicated to the Society by Dr. Buchanan, F.R.S., at a critical period of the Egyptian epidemic of last year. And, lastly, naval medicine finds a place in the volume, where Sir William Smart treats of the fevers to which seamen are specially liable. The papers included in the Transactions thus affect widely different interests, but they all deal with matters with which the epidemiologist is concerned in his efforts to acquire a scientific knowledge of epidemic and allied diseases, and to improve public health both at home and abroad.

Opera Minora. By EDWARD C. SEGUIN, M.D. Putnam's Sons, New York and Henrietta-street, Covent-garden, London. 1884.

IT is not often that a book like the present one is given to the medical profession. Were it not that time is short, we should say, Would there were more of them! This kind of work is really a pleasant companion for reading at leisure. The matter is compounded of a collection of essays, articles, lectures, and addresses delivered by Dr. Seguin from the years 1866 to 1883 inclusive. The volume is dedicated "to his friend and master in the clinical art, Professor W. H. Draper." The contents are naturally of a very varied nature, ranging over the whole extent of practical medicine, and bound together by no other bond than the fact of having been produced by the same pen.

There are many ways in which this book might be reviewed; but as it would serve no good purpose to write an exhaustive account and criticism of the matter, we shall content ourselves with indicating those articles which strike us as needing special comment. There is an instructive article on the subcutaneous use of sulphate of quinine in cases of malarial neuralgia, followed by another on the treatment of malarial fevers by the same method. The question as to the danger of such injections is discussed, and the employment of the hypodermic method is recommended under certain circumstances. A statement of the aphasia question, with a report of fifty cases, is reprinted from the *Journal of Psychological Medicine* of January, 1868. A few pages on hémiplégie spinale are taken from the *Archives de Physiologie Normal et Pathologique* of March, 1880. Considerable space is devoted to a case of traumatic brachial neuralgia. The nerves in the upper cervical region presented the lesions characteristic of chronic neuritis; the arm was finally removed for the cure of the disease. The points of interest are dwelt upon in an exhaustive manner.

A chapter on what may be deemed a small matter designated by the long phrase "On the Inhibitory Arrest of the Act of Sneezing and its Therapeutical Applications" is really worth perusal. The author asks pardon for the introduction of the following non-medical paragraph. "The custom of invoking a blessing upon persons who sneeze is a most interesting one. Several of the old medical authors state that the custom dates from the time of a severe epidemic (in which sneezing was a bad sign) during the pontificate of Gregory the Great. Brand, however, and the author of an article in Rees's Cyclopædia, states that the phrase "God bless you," as addressed to persons having sneezed, is much more ancient, being old in the days of Aristotle. The Greeks appear to have traced it back to the mythical days of Prometheus, who is reported to have blessed his man of clay when he sneezed. In Brand the rabbinical account of the origin of the phrase is given as originating in the alleged fact that it was only through Jacob's struggle with the angel that sneezing ceased to be an act fatal to man. In many countries sneezing has been the subject of congratulations and of hopeful augury. In Mesopotamia and some African towns the populace are reported to have shouted when their monarchs sneezed."

"Hysterical Symptoms in Organic Nervous Affections" does not appear to us to be a good title for a chapter. Symptoms of diseases of the nervous system may or may not exist. There can be no question that disease may be present without any symptoms, but where clinical signs are manifest they must take some shape; their number, like those of the letters of the alphabet, is limited, but permutations and combinations may be effected almost *ad infinitum*. If there be disordered action of any part of a nervous system, we have certain indications; but these manifestations in themselves cannot with certainty tell us the nature of the disordered action.

The book is rich in articles on diseases of the nervous system. Eight lectures on localisation are all that can be desired. Locomotor ataxia and chronic trigeminal neuralgia are well treated. "The present aspect of the question of tetanoid paraplegia," or spastic spinal paralysis (Erb), is an article bearing date 1879, from which we gather that Dr. Seguin was certainly amongst the first to describe the symptomatology of the disease. In an essay on the efficacy of iodide of potassium in non-syphilitic organic diseases of the central nervous system, Dr. Seguin says: "Even if the iodide cannot cure organic diseases of the brain, it seems to relieve symptoms. If by the free use of such a remedy, one not directly harmful, we can diminish intracranial tension, remove œdema, or perhaps check the growth of some neoplasm, thereby relieving pain and other distressing symptoms, would this not be a gain to our therapeutics?" On arsenical paralysis, the author concludes that it is the expression of a myelitis, probably of a diffuse character, with special involvement of the anterior grey matter. The last chapter is one on the cultivation of specialties in medicine, in which Dr. Seguin says he has endeavoured to show that the growth of specialties has been normal and in accord with the general scientific movement of the age; that specialties are useful to the public and to medical science; and that the practice of a specialty is not unattended by intellectual dangers.

MR. T. THORPE DELASAUX, of Canterbury, the oldest coroner in England, having held that office for East Kent for sixty-four years, died last week. He had recently attained his eighty-seventh birthday.

New Inventions.

MESSRS. PHILIP HARRIS & CO.'S. ANTIDOTE BAG.

WE have received from Messrs. Philip Harris and Co., of Birmingham, an "antidote bag," which, as regards mere mechanical arrangement, is certainly an advance on anything hitherto attempted in this direction. The bag is supposed to contain all that is necessary for the treatment of cases of poisoning, but here unfortunately it fails to answer our expectations. The first requirement in, let us say, a case of opium-poisoning would be a prompt and certain emetic; but we search in vain for a solution of apomorphia. Ipecacuanha wine and sulphate of zinc are there, it is true; but anyone who has had any experience in such a case knows that they constantly fail to induce emesis, even when given in large doses. We find no acid preparation of any kind, with the exception of tannic acid, and are somewhat at a loss to see how it is proposed to treat a case of poisoning by a powerful alkali. Bromide of potassium in large doses is of inestimable value in the treatment of strychnia poisoning, and we should be sorry to have to rely on the chloral solution alone. In poisoning by aconite, atropia and digitalis are the recognised antidotes, but neither is to be found in the bag. The introduction of dried egg albumen is advantageous, but we question the utility of the permanganate of potash solution. The bag is inexpensive, and we can only express our regret that the makers have been badly advised in the selection of the remedies.

A USEFUL ADDITION TO THE BEDCHAMBER.

APPLETON'S patent apparatus for converting any ordinary bedchamber utensil into an inodorous night commode consists of a suitable seat capable of being readily placed upon the top of any ordinary bedchamber utensil, and furnished with a cover lined round the rim with rubber, which hermetically seals the aperture. The apparatus is small enough to be placed in a drawer, and, being coated with non-absorbent material, it cannot retain or give off any objectionable smell. It has the further advantage of obviating the risk of the occurrence of accident by breakage of the bedchamber utensil when in use. The apparatus may be obtained of Messrs. Webster and Larkin, 60, Piccadilly.

A VICTIM OF HEREDITARY INSANITY.

A SOMEWHAT remarkable statement, bearing the signature of M. Paul Bert, has just appeared in the French press. A short time ago a young man named Blin was condemned to death for the murder of a domestic servant in the Palais Royal; and it was noticed that when the sentence was passed upon him he laughed in a nervous sort of way. Blin was a native of the Department of the Yonne; and as M. Paul Bert, who also comes from that district, happened to be staying there, he thought it worth while to inquire into the antecedents of this young man. And this is the story which he has to tell. Thirty-five years ago there lived in the outskirts of the town of Auxerre a tradesman named Blin, who was much respected. He had two sons and two daughters, one of the latter, named Aimée, being noted for her beauty. They had for neighbours a family consisting of the father, mother, and two sons, one of whom was a hunchback and the other a very handsome young man. The girl Aimée Blin was seduced by the latter, and his father and mother would not hear of their marriage. Aimée Blin was confined of a boy, destined to acquire sad notoriety as the murderer of a domestic servant of the Palais Royal, and soon afterwards she went out of her mind, and was placed in the asylum at Auxerre. A few weeks later the seducer went mad, while out shooting, and blew his brains out. His mistress, who had got better, hearing of this when released from the asylum, had a fresh attack of insanity, and threw herself into the river. Her father, who, in spite of what had happened, was much attached to her, also drowned himself, and her mother died of grief. One of her brothers, losing his reason when the Prussians arrived at Auxerre in 1870, went up into a loft and hung himself. M. Paul Bert then relates an incident which forms a curious episode in the ghastly narrative. The dog belonging to the young man who had seduced Aimée Blin refused to leave its master's side when the latter blew his brains out while shooting. It was at last brought back to the house, but it became so surly and vicious that a veterinary surgeon was asked to shoot it. He did so, and buried it in the garden; but during the night he heard some unearthly howling, and descending found that the poor brute, which he had only wounded, had forced its way through the light covering of earth and had dragged itself to the door in agony. A few months later the veterinarian went out of his mind and drowned himself. While all these fatalities were taking place the little boy Blin was growing up, and had the reputation of being very tractable and good-tempered. But, after the death of his grandfather and grandmother, he was entrusted to the care of an aunt in Paris, who treated him very cruelly; and nothing more was heard of him at Auxerre until the murder for which he was tried the other day. "Thus," recapitulates M. Paul Bert, "we have an illegitimate child who was subject during the period of his intra-uterine life to the reaction of the emotion and suffering of his deceived mother; the son of a father who commits suicide; a grandson and nephew of persons who have committed suicide while insane; the victim of cruel treatment, and deprived of maternal care while a child." M. Paul Bert comments upon this sequence of fatalities, and asks: "What is the responsibility of a criminal who laughs at his condemnation, with such hereditary influences and education?"

THE UNIVERSITY OF DURHAM: MEDICAL DEGREES.

AT a meeting which was held at the Kensington Infirmary, on May 23rd, Henry P. Potter, F.R.C.S., in the chair, the following resolutions were passed unanimously:—

1. That this meeting of British practitioners resident in London is of opinion that an alteration in the present regulations for admission to the Practitioner's Examination for M.D. in the University of Durham is desirable in the interest of a large section of the profession, and that it will greatly add to the popularity of the University itself.

2. That the said alterations should be as follows:—(*a*) That Regulation 3, with reference to age, be rescinded. (*b*) That in Regulation 2, the words "fifteen years" be altered to "ten years."

3. That in the opinion of this meeting the chief reasons in favour of the foregoing alterations are:—(*a*) That they would be beneficial to the interests of the University, while they would in no way detract from the value of the degree. (*b*) That they would enable registered medical practitioners to obtain a British degree at a time of life when it is of most use to them in practice. (*c*) That they will induce medical practitioners to present themselves at a British university in lieu of taking a foreign degree.

4. That this meeting trusts the present high standard of the examination will always be fully maintained.

5. That this meeting recommends that the preceding resolutions be embodied in a memorial for presentation to the Senate of the University.

UNIVERSITY OF CAMBRIDGE.—In Easter Term the first examination for the degree of Bachelor of Medicine will commence on June 6th, at 9 A.M., and be continued on the 7th, 9th, 10th, and 11th. The second examination will commence on June 10th, at 9 A.M., instead of 2 P.M., as previously announced, and be continued on the 11th, 12th, 13th, and 14th.—The Rede Lecture, endowments for which were left to the university in 1524 by Sir Robert Rede, was delivered on the 28th inst., the lecturer, who is chosen by the vice-chancellor, being Mr. Francis Galton. The subject was "The Measurement of Human Faculty."

THE LANCET.

LONDON: SATURDAY, MAY 31, 1884.

A GROWING dissatisfaction with the Examining Board in Burlington-gardens has been freely expressed for many years among the teachers in the colleges of arts and science, and in the metropolitan medical schools, and the successful formation of a University in Manchester, which recognises the duty of teaching as well as of examining, has accentuated the difference between the institution in London and a real University. As an Examining Board the University of London has done much to raise the standard of education, especially in scientific subjects; but as religious tests are no longer insisted on at the older Universities, and Science is eagerly pressing its claims and gaining due recognition everywhere, the need for its continued existence on its past lines is not so urgent as at the time of its foundation. At present it fulfils very varied duties in its different sections. By its matriculation and its degrees in Arts and Laws, it performs the simple function of examining and stamping candidates with a mark of proficiency in certain subjects and certain books; it is quite regardless as to how or where such knowledge has been obtained, or what course of previous training the candidate has undergone. Hence it can never be said that a given degree is a proof of classical or mathematical scholarship; it only means that a student has acquired a sufficient knowledge of the books and work included in a given schedule to satisfy the examiners. The examination is severe enough, but may be passed by a hard-working student in spite of a previous training so deficient that he can never be considered a true scholar, and one which would be condemned by every teacher, and even by the examiners themselves if they had known in what it consisted. Such a result must ensue when there is no care for anything but the mere passing of an examination. In the case of the Science degrees, the examinations are mostly of a more practical character, and consequently students who content themselves with mere book knowledge, without a thoroughly efficient course of laboratory work, almost always fail to pass. But even here the University takes no direct interest in the amount or extent of the scientific training which the candidate has undergone previous to his examination; and no examination, however carefully conducted, can, in the short time at the disposal of the examiners, show that the candidates have undergone the best scientific training. The University degree in Science is probably for a practical appointment, as that of a scientific assistant or teacher, less valuable than a certificate from any well-known professor showing the kind of scientific education which a pupil in his laboratory has had. In the case of Medicine the authorities of the University have been strangely but most fortunately inconsistent. The nature and extent of a candidate's studies, and the time which he must have devoted to them, are laid down at every step with the utmost precision. Before he can be admitted to the Intermediate or Final M.B., or even the M.D. examination, various certificates must be forthcoming, and thus a certain course of study is imposed on every medical graduate. We should have been pleased if the same plan had been adopted for the Preliminary Science examination, instead of the regulations to which we have so recently referred. It is for this security of a good training, rather than for the severity of the examinations in medicine, that the medical graduates are indebted to the Senate, and to which their after success is mainly to be attributed. This insistence on a proper education is the great distinction between the regulations governing the medical degrees and those in the other faculties, but even here there is no direct supervision of the members of the teaching body, nor official acquaintance with them, as there is in the older Universities of England, in the Scotch Universities, and in the new Victoria University. Obviously the constitution of the Senate—partly nominees of Government and partly graduates elected from the general body—is fatal to the formation of anything but an examining board; and it is well known that all proposals to enlarge its functions and responsibilities were immediately resisted by the late Vice-Chancellor, who took the narrowest possible view of its duties. Teachers only can constitute a real University, in which teaching takes the first place and examining the second; and it is by their combination alone that a teaching University with a properly connected collegiate system can be formed. Such a University is demanded for the welfare of the general body of students in this metropolis, and when this want is supplied there will be a true University of London in the place of or in addition to a mere Government Examining Board in Burlington-gardens.

THE last volume of the Transactions of the Epidemiological Society contains a paper by Dr. EDWARD C. SEATON on the Influence of Small-pox Hospitals, as judged by the experience he obtained from the isolation of that disease in a hospital situated in the heart of the borough of Nottingham, and capable of receiving some eighty patients; and importance attaches to the paper in that it has been regarded, both in communications addressed to this journal and otherwise, as disproving the theory so ably propounded by Mr. POWER in connexion with his Fulham Hospital inquiry, as to the atmospheric dissemination of the small-pox poison from that institution, where patients suffering from the disease were aggregated together.

Dr. SEATON brings forward a number of arguments against the theory of atmospheric diffusion. In the first place, he points out that certain groups of cases within a quarter of a mile, half a mile, and three-quarters of a mile of the hospital could much more easily be accounted for by direct infection from badly isolated cases in their immediate vicinity than by any other theory; and he proceeds to explain how cases became grouped around such places as (1) the shop of a barber who, whilst continuing his business, had his wife and mother lying ill of small-pox within a few feet of the place where the customers were shaved; (2) a journeyman tailor, who, being an anti-vaccinationist, continued his work with a secreted case of confluent small-pox at home; and (3) a tripe-shop, where the person who nursed the patient also waited in the shop. As to such instances, we would point out that they show no more than that small-pox is infectious, and they can have but little bearing upon

such an inquiry as that made by Mr. POWER, because he was able to prove that, as regards the special groups of cases around the Fulham Hospital where the disease first showed its tendency to spread, no similar sources of infection had come into play. From this point of view, therefore, the Nottingham case is not a parallel one to that of Fulham.

Then, again, Dr. SEATON points out that groups of attacks were separated from each other by broad belts of populous districts which were almost clear; and, further, that the number of cases was greater in the group near to the half-mile ring, drawn from the hospital as a centre, and between that and the three-quarter-mile ring, than close to the hospital. As to the first point, this is doubtless to be in part accounted for by the centres of infection already referred to, and possibly also by difference of susceptibility owing to vaccination—a source of error which creeps in to vitiate so many similar inquiries. With regard to the second point, the actual number of cases is unimportant compared with the proportion of attacks to population; and since, according to Dr. SEATON'S map, each of the two outer rings appear to contain a larger population than the quarter-mile ring does, the fact that the former rings may have contained a larger number of attacks in no way affects the question. As a matter of fact, forty-four cases are shown in the smaller population within the quarter-mile circle, fifty amongst the larger population in the quarter-mile to half-mile circle, and forty-two in the half-mile to three-quarter-mile circle. In short, so far as we can judge from the shading, which is intended to represent extent of population, the results happen to be very similar to those observed around Fulham by Mr. POWER. Indeed, Dr. SEATON seems to have noted this point, for whilst maintaining that the total number of cases bore a relation to the numbers of centres of infection in the respective circles, he admits that they also "appeared to show a relation to their distance from the hospital."

Another point raised by Dr. SEATON is that in Nottingham there was no simultaneous outburst of cases, and as to this he proceeds to imply that such probably would have been the case had atmospheric diffusion come into operation. How far such a supposition holds good we have no data to show; indeed, all we appear to know about the subject is that under the circumstances of aggregation, of meteorology, and otherwise which did occur at Fulham in one special fortnight, there was a somewhat sudden outbreak. Dr. SEATON admits that the diffusion in Nottingham took place almost entirely in the direction in which the prevailing wind could have conveyed it from the hospital, but he considers he has proved that other sources of infection amply accounted for the special localisation of the epidemic.

We are not proposing to deal with all Dr. SEATON'S arguments on the present occasion; and for this reason: we do not for a moment mean to imply that at Nottingham the diffusion which took place around the hospital may not mainly have been due to other causes than those which have been regarded as coming under the designation of aerial influence, although we cannot help suspecting that such influence was not altogether absent. What we do assert is that the Nottingham experience in no way refutes that recorded in connexion with Fulham. So far as we are aware, it has never been contended that every aggregation of small-pox patients has led or will in the future lead to such results; indeed there is every reason to believe that the conditions favouring the Fulham diffusion were, both as regards quality of cases under treatment and prevailing meteorological conditions, specially favourable to the dissemination of small-pox which ensued. But what we do believe is that under the Fulham conditions a spread of the disease to the surrounding population did take place; and the mere discovery that at Nottingham other well-known sources of infection were in operation, which the most skilled investigation at Fulham enabled Mr. POWER to set aside as not there coming into play, can in no way be regarded as affecting the conclusions arrived at as to the operation of an aerial diffusion at Fulham. The special warning conveyed by Mr. POWER'S report is, that what has happened once under conditions so obscure that they cannot as yet be met, may, when those same conditions again co-operate, once more recur. The warning still holds good notwithstanding the Nottingham experience.

In our next issue we shall have some criticisms to offer on the objections raised in our columns by Dr. EDWARD WILSON to Mr. POWER'S conclusions.

AT the meeting of the Medical and Chirurgical Society on Tuesday last, two important papers on the Surgical Treatment of Affections of the Lung were read and discussed. Dr. CAYLEY related a case of pyæmic pulmonary gangrene, in which Mr. GOULD had passed a drainage-tube into the lung and drained the cavity; the child, who was in an extremely exhausted state at the time of the operation, ultimately making an excellent recovery. Dr. BISS reported a case of abscess in the base of the left lung, bronchiectatic in origin, which was opened and drained by Mr. MARSHALL, with the result of obtaining marked relief, although the man ultimately died of abscess of the brain. To a large extent the discussion which followed consisted of shorter records of other cases in which attempts had been made to open and drain pulmonary abscesses by direct surgical interference; thus, Mr. GODLEE referred to two cases, in one of which the cavity was drained through an external wound with considerable relief, while in the other attempts had been made without success to reach either of two large cavities which had been diagnosed to exist in the lung of a young child. Dr. KINGSTON FOWLER gave an account of a remarkable case in which a molar tooth passed into the right lung and set up suppuration, and in which drainage through an external opening had proved of decided benefit, although the tooth could not be found and had not escaped. Dr. BROADBENT also related a case of incision into a very large basic cavity in which the surgical interference was attended with at least considerable temporary advantage; and Mr. WALSHAM referred to a case of abscess at the apex of the chest which burst externally, and in which he enlarged the fistulous opening, the case ultimately doing well; but in this instance there is room for doubt whether the collection of pus were not a loculated empyema rather than a pulmonary abscess. These facts show in what direction many physicians are now looking for aid in the treatment of these serious affections of the lungs. Little by little

experience is being accumulated, and the discussion of Tuesday will do much to focus attention upon the subject in this country, and we may hope soon to add to our knowledge of the limits within which surgical interference is justified and is called for. At present the practice is largely experimental, and possibly, from the difficulties surrounding the diagnosis and the surgical manipulation, there may always remain some element of chance in thus attacking a pulmonary cavity. Such experimental stage is the necessary precursor of all advance, and it must not be allowed to excite prejudice or disappointment if it reveals errors as well as truth.

It is well to ask the question, What are the data from which we start in discussing this question? The first fact, which forms the great justification for the attempts now being made, is the desperate nature of the cases if left to themselves; added to which we have the comparative impotence of known medical means of relief, and the certainty and success with which similar affections in other situations are dealt with surgically. It is this consideration that must ever be uppermost in the mind when discussing this question, and the aim of all experiments must be to assimilate, so far as is possible, the operative measures on the lung to those employed in other regions, bearing in mind the special anatomical arrangements and physiological importance of the respiratory organs. Further, it has been shown that the diagnosis of the suitable cases is a matter of considerable difficulty; where all the physical signs point conclusively to the existence of a considerable excavation, even repeated exploration may fail to find a cavity; it may be, and often is, impossible to tell whether there are one or more cavities, while so expert a diagnostician as Dr. DOUGLAS POWELL confesses that there is no reliable sign of the adhesion of the two layers of the pleura—a condition always desirable before operation is undertaken. We are also able to assert that incisions, and especially punctures, may be made into healthy or into diseased lung tissue without any special fear; hæmorrhage may be free, but it appears to be readily stopped by pressure, and at any rate it offers no obstacle to this mode of treatment. Thus far no case has been recorded in which pneumothorax or pyo-pneumothorax has resulted from opening a pulmonary abscess, but one of the instances referred to by Mr. GODLEE shows that cases may arise in which the physician seeks the surgeon's aid where the pleural sac is not obliterated. It is unwise to dogmatise in reference to a matter about which we have insufficient data; but KRÖNLEIN'S case (see THE LANCET, March 8th, 1884, p. 430), and many other cases of pneumothorax, show that that condition, even when it occurs, may be spontaneously recovered from. KRÖNLEIN has also recorded a case of pyo-pneumothorax in which, when he opened the pleural sac, he saw a sloughy abscess cavity in the collapsed lung; this he washed out freely and drained with the best results.

What, then, are the points still awaiting decision? The first is, no doubt, the real value of surgical interference, what it is able to accomplish, and what it is powerless to do. That it can efficiently drain a gangrenous pulmonary cavity the case brought forward by Dr. CAYLEY and Mr. GOULD clearly shows, and we suppose that this case alone is ample warrant for a repetition of the same treatment in any case of pulmonary gangrene threatening life, and where the diseased process can be localised. But the evacuation and cicatrisation of an embolic sphacelus is not the same thing as the drainage and permanent closure of a pulmonary abscess or bronchiectatic cavity. Here the surrounding induration of the lung, and the chronic nature of the affection, as well as the free communication with a large mucus-secreting surface, hinder the permanent closure of the cavity, even if it be drained, while the impossibility of certainly entering the cavity at its lowest part, as well as the movement which the lungs undergo in respiration, are other serious hindrances to permanent closure and firm cicatrisation of such cavities.

But the cases which have been thus far recorded in which cure was not obtained have been so much benefited by the operation that it will have to be considered carefully whether the palliation obtained does not justify surgical interference, even where cure is not to be expected. To convert a putrid cavity discharging its foul contents through the mouth into a thoracic fistula, the secretion from which can be easily kept sweet, relieves the patient's distress, even when it fails to prolong life.

So far, then, our limited experience warrants us in recommending operation for cases of localised gangrene of lung in the hope of curing an otherwise hopeless affection. In cases of single basic cavities, with profuse suppuration, and particularly where the secretion is fetid, an attempt should be made to reach and drain the cavity, with the aim of relieving the patient's chief distress, of lessening the secretion, and aiding contraction of the cavity, even if entire cicatrisation be not ultimately secured. There does not appear to be any warrant to treat in a similar manner tubercular cavities, and the more nearly the suppurating cavities approach to single local necrotic foci, the more suitable are they for operative interference. The operation which at present seems to be most suitable is the exploration of the part with a trocar and the introduction of a good-sized drainage-tube when the cavity has been reached. It may be that further experience will show the wisdom of more extensive operations, such as excision of the rib, to obtain a freer access to the diseased lung, but at present such a step should only be taken when the simpler procedure has failed, or is from any other cause unsuitable.

THE choice of the electors to the newly founded Chair of Pathology in the University of Cambridge fell last Saturday on Dr. CHARLES SMART ROY, Professor Superintendent of the Brown Institution. Dr. ROY'S labours have hitherto been chiefly in the direction of experimental physiology, in which he has done much valuable work and contributed many important papers to the scientific periodicals and Societies. He has not, we believe, as yet, devoted much time to the teaching of practical pathology such as we are accustomed to see taught in the London medical schools, and it remains to be seen whether the new professor intends to organise the teaching of pathology in that direction or to devote himself chiefly to experimental research. It is, at present, a debatable matter among many whether the University should be developed as a medical school, or whether the teaching should be purely scientific. One or other line should be decidedly adopted,

for we fear there will hardly be room for both for some time to come. The elements for sound practical teaching had been laid many years ago by Professor HUMPHRY'S lectures on Anatomy, and after the creation of a chair of Physiology, medical students in considerable numbers were encouraged to enter at the University with a view to being able to graduate, and at the same time to pursue their anatomical and physiological studies and to pass their primary examination in London. Coincident with this activity in the medical school a great development in the scientific teaching took place, which certainly has of late obscured, if not superseded, the original intention of founding a school of medicine. This last appointment seems to be a further indication of a desire on the part of the authorities, to make the University a school for the prosecution of scientific research rather than for the practical purpose of medical teaching and training. How far this decision will affect the University time will prove, but we fear it will blight the hopes of those who were looking forward to the establishment of a practical school of medicine at Cambridge. Without offering an opinion either way, we cannot close our eyes to the fact that a considerable number of the leading Cambridge medical graduates in London are of opinion that an extension of the practical medical teaching at the University is what at present is chiefly required, and that sufficient facilities already exist for purely scientific research.

Annotations.

"Ne quid nimis."

ELECTION OF FELLOWS OF THE ROYAL COLLEGE OF PHYSICIANS.

CONSIDERABLE dissatisfaction has been expressed at the list of Members nominated for election to the Fellowship by the Council of the Royal College of Physicians for the current year. It lies not so much in the fault of commission, though some of the names proposed will excite surprise, but in the omission of the names of many members connected with the leading hospitals and metropolitan schools, whose work and position in the profession certainly have entitled them to receive the honour at an early date. We have always advocated the liberal bestowal of the Fellowship on those senior members of the profession who have acquired a distinguished position not so much by work as by a high-toned, blameless, and cultured professional life, and we have also claimed for provincial Members a due share of representation among the Fellows; but we have more especially urged the claims of the junior Members, who by their work at the hospitals, the medical schools, and the societies, have proved themselves thoroughly good men, and who by following in this direction can look to little beyond distinction for many years to come. To defer the honour in these cases is an injustice, whilst to confer it after considerable postponement is a very doubtful honour. Election to the Fellowship after only four or five years of probation is a distinction which ought to be regarded as the highest professional prize, but its value is considerably diminished if deferred for seven or eight years. On going to press we learn that the list in question was at the Comitia referred to the Council for reconsideration.

THE COUNCIL OF THE COLLEGE OF SURGEONS AND REFORM.

MR. PAUL SWAIN has issued a reply post card to the Fellows of the Royal College of Surgeons soliciting a written agreement with the principles expressed in the resolutions adopted at the meeting of Fellows and Members held at the College on March 24th last, but which have been disregarded by the Council. The resolutions are as follows:—1. "That in the opinion of this meeting it will materially conduce to the welfare of the College that the Fellows and Members should be invested with a larger share of its management. 2. That it is desirable that no alteration in the constitution or relations of the College shall be effected without the consent of the Fellows and Members convened to discuss such alteration. 3. That there shall be an annual meeting of the Fellows and Members, at which the annual report of the Council shall be presented, received, and adopted. 4. That at such meeting the President for the ensuing year be elected by a majority of the Fellows present." Those who express agreement with the principle of these recommendations are likewise asked to join an Association of Fellows to promote reform. This body is not a revival of the old Association, which, for many reasons, failed to secure the confidence of many of the most influential Fellows, and which finally became defunct by a declaration read at the general meeting held in the College last March. We would urge every Fellow receiving Mr. Swain's post card to give it immediate attention, and thereby to strengthen the hands of those within and without the Council who wish to place the College *en rapport* with the times.

THE NERVE PLEXUSES OF THE INTESTINE IN PERNICIOUS ANÆMIA.

THE intimate connexion between so-called pernicious anæmia and gastro-intestinal derangement has long excited attention, and has led to various suggestions as to the relation between the conditions. There can be little doubt that in some cases a fatal progressive anæmia appears to be initiated by symptoms of disorder of the stomach and intestine, especially vomiting and diarrhœa; so that both Dr. Austin Flint in America and Dr. Fenwick in this country have some reason for their belief in a primary atrophic condition of the gastric lining being a cause of the general blood impoverishment. In the current number of Virchow's *Archiv* (Band 96, Heft 2), Dr. Sasaki, of Tokio, gives the results of his examination of the intestinal nerve ganglia in two cases of pernicious anæmia, and the fact that he had examined the condition of the nerve apparatus in about fifty intestines gives to his statements considerable weight. The research was carried on at the Strasburg Pathological Institute. Jürgens and Blaschko have already signalised the discovery of degenerative changes in these structures, and regarded them as special diseases. The cases now related by Sasaki ran the clinical course of pernicious anæmia, but in each there was a history of attacks of gastralgia with vomiting, and in one of diarrhœa. Not to burden this summary with details, it may be here said that very marked changes of a degenerative kind were detected in the plexuses of Auerbach and Meissner in each of these two cases. In the first case the ganglia cells were shrunken, very granular, pigmented, and deprived of their nuclei; many of them had the glistening homogeneous character described by R. Maier in lead poisoning. Between these cells was the finely granular detritus of other cells, but there was no apparent change in the connective substance. The nerve fibres were very degenerate, staining badly or not at all. There were also, especially in Auerbach's plexus, a large number of small glistening bodies, resembling very

much in appearance and reactions the corpora amylacea of the spinal cord. Similar bodies have also been found in many chronic intestinal affections, and indicate an atrophic state. The muscular fibres of the intestine were thin and granular; the bloodvessels showed no change; the villi were small and granular, and the cells of Lieberkühn's glands also broken up. In the second case, although there was no thinning of the intestinal wall, there was marked fatty degeneration of Auerbach's plexus throughout its whole extent, and also of the muscular coat. In the plexus fat globules were scattered between as well as within the nerve cells. Meissner's plexus was less diseased, but many of its cells were wholly deformed. Sasaki points out that Lepine divides pernicious anæmia into three groups—(1) the splenic and myelogenic, (2) the gastro-intestinal, and (3) the cases occurring in pregnancy; and that Eichorst states that of ninety-one cases, in twenty-four obstinate vomiting and diarrhœa occurred at the onset. Quincke, too, has related a case in which anæmia supervened after three years' suffering from gastralgia and vomiting, when the gastric mucosa was found to be much atrophied. And the cases of Flint and Fenwick might also be added to the list. In order to test the view taken as to the relation between these changes in the intestinal nerves and pernicious anæmia, Sasaki examined the intestines in eighteen cases where the intestinal walls were atrophied in the course of phthisis, cancer, or old age. He found, especially in cancerous subjects, some fatty granules in the nerve plexuses, but mostly around the nerve cells, which were always seen to be of normal size and form. In such cases the condition was, he thinks, one of fatty infiltration, rather than degeneration, and they markedly contrasted with the profound disintegrating lesions met with in the subjects of progressive anæmia. From these and other considerations, he concludes it to be highly probable that the gastro-intestinal variety of so-called pernicious anæmia depends on anatomical changes in the intestine; that pernicious anæmia may arise from an intestinal atrophy, the concomitant change in the intestinal nerves being a parenchymatous degeneration; but that limited changes in these plexuses, as distinguished from the generally diffused degeneration above described, are connected with local lesions of the intestine. As a contribution to our knowledge of the pathology of the sympathetic nerve this work is to be welcomed, for it opens up a field of research which may profitably be pursued in connexion with many of the viscera.

THE PREVALENCE OF SMALL-POX IN THE METROPOLIS.

THE increase in the prevalence of small-pox within the metropolis is attracting general attention, and it was in view of it that Dr. Cameron last week submitted his rather complicated question, as to general administration in connexion with isolation and vaccination, to the President of the Local Government Board. The state of affairs is certainly serious, for apart from deaths on board the *Atlas* and in the Darenth Camp Hospital, the small-pox mortality increased from 11 in the week ending May 3rd to 42 in the week ending May 17th. So also the number of small-pox patients in the Asylums Board hospitals has increased in nine weeks from 148 to 924. We strongly doubt whether Dr. Cameron's questions addressed themselves to the real source of mischief. Fulham Small-pox Hospital has been proved to have acted as a centre of disease rather than as a means of staying infection. Homerton Hospital must now be regarded as acting in a similar way. Indeed the inquiries instituted by Dr. Tripe prove as to that hospital precisely the same as was proved in the case of the Fulham Hospital; the amount of small-pox around it being greatest as regards those living near it, and fading away as the distance from it increases. Thus, the proportion of attacks to population living within a quarter of a mile of the hospital is about 2·0 per 1000, between a quarter of a mile and half a mile it is 0·50 per 1000, between half a mile and one mile it is 0·27 per 1000, and in the remainder of the Hackney district it is only 0·14 per 1000. The same incidence of small-pox upon the hospital area is shown by the remark of the Registrar-General, that of the total of 42 small-pox deaths which occurred in the metropolis in the week ending May 17th, as many as 34 belonged to Hackney and to East London. Very grave doubts are arising as to whether the aggregation of small-pox cases in the metropolis for the purposes of isolation is not doing more harm than good, and it may be that some day the steps which have been taken in this direction will have to be retraced, for much the same reason that inoculation for small-pox had formerly to be prohibited.

SUICIDE AND SLEEPLESSNESS.

THE circumstances attending the death of the Dean of Bangor—albeit they are infinitely distressing—present no novel features. The reverend gentleman was a man of considerable intellectual "power," which is the same thing as saying that he was constitutionally liable to intervals of mental depression. All highly intellectual men are exposed to this evil. A pendulum will always swing just as far in one direction as it does in the other. Great power of mind implies also great weakness under certain conditions. The marvel is not that great minds occasionally become deranged, but that they so often escape derangement. Sleeplessness means not merely unrest, but starvation of the cerebrum. The brain cannot recuperate, or, in other words, it cannot rest. Physiologically, recuperation and rest are the same thing. Sleep is simply physiological rest. The only cause for regret in these cases is that the blunder should ever be committed of supposing that a stupefying drug which throws the brain into a condition that mimics and burlesques sleep can do good. It is deceptive to give narcotics in a case of this type. The stupor simply masks the danger. Better far let the insomnious patient exhaust himself than stupefy him. Chloral, bromide, and the rest of the poisons that produce a semblance of sleep are so many snares in such cases. Sleeplessness is a malady of the most formidable character, but it is not to be treated by intoxicating the organ upon which the stress of the trouble falls. Suicide, which occurs at the very outset of derangement and is apt to appear a sane act, is the logical issue of failure of nutrition that results from want of sleep. It is curious to note how a sleepless patient will set to work with all the calmness and forethought of intelligent sanity to compass his death. He is not insane in any technical sense. He has no delusion. He does not act, or suppose himself to act, under an "influence." He simply wants to die, and, perhaps, not until after he has made an attempt to kill himself will he exhibit any of the formulated symptoms of mental disease.

MONTHLY NURSES AND INFECTIOUS CASES.

A CORRESPONDENCE between two medical men on the above subject has been forwarded to us. The wife and two children of one of these gentlemen had scarlet fever. He sent for a monthly nurse to tend them. Learning of her engagement to nurse the obstetric case of a medical neighbour, he wrote to this gentleman asking him to request the husband to send for the nurse to his house (where the three cases of scarlet fever were) when she was wanted but without stating the nature of his wife's illness. This letter and its request so surprised the medical man to whom it was addressed that he could only find relief in forwarding the correspondence to us. We withhold the publication of it for the sake of avoiding personality; but we must say that but for the copy of the actual correspondence, we could

scarcely have believed that a medical man could have acted so. When the nurse was actually fetched to the obstetric patient, the duration of the earliest of the cases had not been a month, and that of the latest less than three weeks. She was of course immediately dismissed by direction of the medical man who forwards the correspondence to us. We are constantly appalled by the selfishness of patients, who carelessly expose themselves in an infected state, or refuse to take the most obvious precautions not to spread disease. Then how can we blame the public when a medical man can deliberately send for a monthly nurse to tend three scarlet fever patients in his house, and ask a brother practitioner to arrange that she shall be sent for when wanted, and go reeking with infection to nurse a lying-in woman, and be in constant contact with her three or four young children. We withhold further remark in reliance on the publication of the facts as a sufficient rebuke and warning to all concerned.

ALLEGED OFFICIAL NEGLECT OF SMALL-POX.

A CURIOUS story as to the difficulty of finding means for the isolation of cases of small-pox is reported in the public press as having occurred at the Princess Louise Home for the Protection of Young Girls, at Wanstead, in Essex. According to Mr. Gillham, the secretary, it would appear that small-pox broke out in the Home early this month, and that Mr. Gillham at once made efforts to get the patients removed to a hospital. He first approached the vaccination officer, but the duties of this official relate to the vaccination of infants, and not to hospitals; thence he was sent to the relieving officer, but, as it can be hardly assumed that the girls in the Home were paupers, relief in the sense of the Poor Law was not needed, and hence not given; then the sanitary inspector and the officer of health were appealed to, and these certainly are the officers to whom the visit should, in the first instance, have been paid; but still they did nothing for him. So far as we can judge, Wanstead appears to be partly in the urban and partly in the rural district of West Ham; and we can only assume that, the sanitary authority concerned having failed to provide the means of isolation for infectious diseases which the Public Health Act empowers them to keep in readiness, their officers were helpless. Mr. Gillham, next day, appealed to the Local Government Board, and he says his messenger soon returned with a memorandum saying they could do nothing to assist him. This is certainly a statement which should be cleared up. The Local Government Board, as is well known, possess memoranda which they freely distribute on similar occasions, pointing out precisely what are the duties which should be performed by the sanitary authorities and by the guardians as the vaccination authority respectively under these circumstances, and it seems incredible that nothing but a refusal "to assist" could have been the result of this application to the central authority. Mr. Gillham should give details as to the contents of the memorandum, which he says was given to his messenger by the officials at Whitehall, and also of the letter which followed. Finally, after an unsuccessful attempt to get extra-metropolitan cases of small-pox into the hospital at Homerton, where the inhabitants think they have already enough of their own London cases, the girls were admitted into the Small-pox Hospital at Highgate. Between these delays a *contretemps* occurred which, if correctly stated, is the reverse of creditable. We are told that the authorities at Highgate possess no ambulance, and hence that a vehicle at Nottinghill-gate was procured for the removal of patients. We hope there is some error here, for having regard to the dangers attaching to the removal of small-pox patients by irresponsible persons, and in conveyances other than those which are under strict supervision, we should have thought that an establishment which existed for the purpose of receiving small-pox patients would have provided itself with adequate means for their removal there with safety to the sick and to the public. Lastly, writing on May 27th, Mr. Gillham says that cases have continued to be sent from the Home to Highgate, and that four fresh cases went on that day. This seems astounding in view of the fact that the first cases occurred "early this month," and that Mr. Gillham has been again and again in communication with the very officers and officials who always draw attention to the need for vaccination in view of such emergencies as he describes. We should be glad to learn from Mr. Gillham whether any of those whom he consulted advised the immediate vaccination or revaccination of the inmates of the Home, and, if so, whether the advice was at once carried out or not. Until some of these points are cleared up, it is impossible to state with whom lies the main responsibility for this course of blundering and neglect. In a letter received at the moment of going to press, Dr. Whitehouse, medical officer to the asylum, states that all the inmates had been vaccinated prior to their admission, but were not revaccinated until the outbreak of small-pox in the institution.

ANTHROPOMETRY.

AN anthropometrical laboratory will be opened at the Health Exhibition in the course of the ensuing week. The laboratory has been organised by Mr. Francis Galton, and it will be the means of showing to the public at large how certain personal facts may, with care, be measured and recorded. In order to prevent crowding, a small fee will be charged for admission. Each person who enters will be furnished with a pamphlet explanatory of the objects of anthropometry, and included in the pamphlet will be a schedule with blank spaces, which will be filled up in the course of the passage of the visitor through the laboratory. The completed schedule will contain a record of name (or initials), age, sex, occupation, place of birth, colour of hair and eyes, height standing and sitting, weight, length of span of arms, strength of squeeze and pull, swiftness of direct blow, capacity of chest as measured by a spirometer, acuteness of vision as measured by a test type, conditions of colour sense, and acuity of hearing. It is not improbable that this "laboratory" may become rather a favourite resort for visitors to the Exhibition, in which case a large mass of facts will be collected (for a duplicate schedule will be retained by the attendant), which will doubtless be turned to good account by Mr. Galton.

NERVE SUTURE.

RECORDS of cases of suture of nerves divided by injuries, or, at any rate, of cases in which a considerable interval has elapsed between the injury and the operation, are not as yet so numerous as to be passed by without notice. In the *Berliner Klinische Wochenschrift* of May 26th, Dr. Reger of Potsdam gives an account of such a case. The patient, a young man, received a severe incised wound of the outer side of the arm, which was accompanied by much hæmorrhage and by paralysis of the forearm, and the healing of which was much delayed by suppuration. Two months later Dr. Reger saw the case and found a large scar, beneath which, in the interval between the triceps and biceps, the radial nerve-trunk could be felt. The limb, especially the forearm and hand, was much wasted and its muscles flabby; there was paralysis of the extensors of the hand, and pronation and supination were impossible; sensation and electric excitability of the dorsum of the hand and arm below the scar were also abolished. After a course of electrical treatment nerve suture was determined on. The operation, which took place four months after the accident, was per-

formed under local anæsthesia and antiseptic measures. On dividing the scar transversely by a large incision, the peripheral end of the severed nerve was readily displayed, but the central end was less easily found, it having retracted considerably. There was a marked difference in the appearance of these portions, the central end being somewhat bulbous and rose-coloured, besides sensitive to mechanical irritation; the peripheral stump, on the contrary, was conical, shrivelled, pale, and unexcitable. A distance of one centimetre and a half separated these two ends, which was increased by another centimetre after the surfaces had been pared. By detaching the sheaths for a certain distance, and slightly flexing the elbow, the suture, with a curved needle and catgut, was effected. The wound was washed with carbolic solution, dressed with iodoform, a drain being made of strands of catgut; it healed by the first intention. Sensation in the fingers began to return on the third day, and slight power of movement also. Under electrical treatment the functions were at length wholly restored. The author thinks this case one of the best in its results of those which have been published. He draws especial attention to the procedure of freely exposing and detaching the nerve, and of the employment of catgut.

THE PROMOTION OF DR. ACLAND TO K.C.B.

THE promotion by Her Majesty of Dr. Acland, C.B., M.D., Regius Professor of Medicine in the University of Oxford, to be Knight Commander of the Most Honourable Order of the Bath, will be regarded by the profession with much satisfaction. We looked anxiously through the list in the Supplement to the *Gazette* for the announcement of a like promotion to a colleague of Dr. Acland's in the Medical Council, but with disappointment. Dr. Acland well deserves to be a K.C.B. For more than a generation he has held a conspicuous position in the profession and in several representative relations, and his influence has been always on the side of good. Sometimes we have wished that it might have been exerted with more strength of assertion. But *suaviter in modo* is the strength of some men. It is so with Dr. Acland. The profession has sometimes thought that he might have done more for medicine at the ancient University of England than he has done. But he has done more, perhaps, than many think, and has had to overcome more resistance than is generally realised by his critics. Of late he has done yeoman's service on the side of those who wish to keep alive in Oxford the science of Life and all that it involves. He has done almost equally well in the plain words of conviction which he spoke in favour of immediate legislation for the better ordering of medical education and the better organising of those boards by which it is tested. We heartily wish Sir H. W. Acland the long enjoyment of his well-earned honour.

CARBONIC ACID POISONING.

IT seems to be forgotten that there is an important difference of effect between carbonic acid and carbonic oxide. It used to be supposed that, in the last degree, carbonised blood acts differently from blood simply deficient in oxygen; that carbonic acid when it accumulates in the blood to a certain point acts as a stimulus to the nervous centres. The contrary opinion is now held by physiologists—namely, that it is the deficiency of oxygen, and not the accumulation of carbonic acid, which excites convulsive efforts to breathe. However this may be, it is certain that the mere struggling of an animal towards the end of a prolonged effort to carbonise its blood does not necessarily imply consciousness or sensation. At the same time, we are bound to admit that both consciousness and renewed sensibility may occur when either the blood of any animal becomes so charged with carbonic acid as to excite the central and automatic nerve centres or the demand for oxygen is so urgent that the organism brings every muscle into play in the effort to obtain it. The phenomenon of re-awaking, however it may be caused, is akin to the flaring up of a spark before it finally expires. We make these remarks *à propos* of an inquiry instituted by the Board of Shechita.

VACCINATION WITH CALF LYMPH.

AT the closing meeting for the session of the Islington Medical Society on Tuesday evening, Mr. Shirley Murphy made a very interesting statement as to the operation of the system of vaccinating with calf lymph at the station at Lamb's Conduit-street. The lymph is taken from the calf at the end of five times twenty-four hours from its vaccination. If the lymph is not taken for twenty-four or forty-eight hours later, there are less satisfactory results. Great care is taken in the selection of a healthy calf, and also in attempts to keep it in good condition—the calf being very sensitive to chills, errors of diet, &c. The insertion-success of the vaccination is very great. Thus, out of the last 300 children vaccinated in five places, only one insertion failed. The success with which the vaccination "takes" is accounted for chiefly by the large quantity of material which is secured from the calves, five of which are vaccinated weekly in about sixty places. The lymph, if not used direct, is best stored on points. The first calf was vaccinated from a case of spontaneous cow-pox near Bordeaux on Nov. 26th, 1881. Altogether 440 calves have been vaccinated. The best results are obtained with good English calves. The calves under vaccination, in spite of a slight rise in temperature, improve in condition and weight, doubtless from the care with which they are fed and tended. Over two thousand children have been vaccinated with calf lymph. It is too soon to speak positively of the protective power of such vaccination; but there is reason to think it the same as that conferred by human lymph. In fact, the chief thing learnt by the use of calf lymph so far is that there is no great difference between its effects and those of human lymph. The vesicles are almost exactly the same size, the areola has almost the same extent, and the course taken is practically the same. The one advantage is the exclusion of the risk of syphilis, but this is so rare an accident, one apparently so difficult to produce with human lymph, and certainly so easily avoidable with proper care, that the difference counts but little.

OXFORD GRADUATES' MEDICAL CLUB.

THE inaugural dinner of this latest of all similar clubs took place on Thursday last. The chair was taken by Dr. Fincham at 7 P.M., after a general meeting of the members, at which the appointments of officers for the current year and the rules, which had already been sent to the members, were confirmed. Professors Burdon Sanderson and Acland were present, with Drs. Munro, Church, Corfield, Shepherd, Payne, and about fifty other members of the Club. The object being entirely social, the speeches were limited in number. The President, after giving the usual loyal toasts, proposed the health and prosperity of the Club, and in a few short and appropriate sentences, which were warmly applauded, sketched the history of its formation and the objects which it sought to promote, these being to maintain association with the university and to promote good fellowship among the members of the Club. The toast was enthusiastically received. The President's health was next proposed by Dr. Acland, who alluded to his career in graceful terms, and sketched the alterations which had taken place in the number of candidates for the M.B. during the last thirty years. In replying to the toast, Dr. Fincham

spoke in eulogistic terms of the work of the secretaries, who had succeeded in bringing together so large a gathering on this occasion, and who, notwithstanding the difficulties of getting the names and addresses of those qualified to become members, had succeeded in publishing the first list of more than 80 members of the Club out of little more than 120. Mr. John H. Morgan and Dr. Samuel West, in reply, stated that they were amply repaid for their labours by the success which had been generally expressed as to this preliminary gathering, and in apologising for oversights and shortcomings begged for the assistance of all present. The energy and kindness of Dr. Shepherd, who had initiated this movement, were also gracefully alluded to. The next meeting has been arranged to take place in November, when members will have the privilege of introducing guests.

MR. TEALE ON THE LEEDS REPORT ON SCHOOL PRESSURE.

MR. TEALE, in a letter to the *Yorkshire Post* of May 8th, on the Leeds School Board Report on Overstrain, expresses his dissatisfaction with the investigation and his dissent from the conclusions. The following is the concluding paragraph of the letter:—

"Having undertaken as a public duty this critical review of the report of the Leeds School Board on Over-pressure, I have deliberately come to the conclusion that it is not judicial, that it is not a correct deduction from the facts collected and presented, that the facts have not been exhaustively collected, that they have not been carefully weighed by the committee, nor impartially weighed without bias. Let those who will take the trouble to study the report judge whether my verdict be true or not."

The letter is one that should be studied by all who wish to go critically into this complicated question.

THE FIFTH INTERNATIONAL CONGRESS OF HYGIENE.

NOTICES have been issued by the committee of organisation that this Congress will be opened at the Hague on the 21st of August, and will conclude its proceedings on the 27th of the same month. Applications for membership may at once be made, and should be addressed to the general secretary, Dr. van Overbeek de Meijer, Professor of Hygiene at the University, Utrecht, Holland. The subscription amounts to only ten florins in Dutch money, and this entitles members to a copy of the report of the proceedings and a reduction in their railway fares. In its general organisation this Congress will resemble its predecessors held at Brussels, Paris, Turin, and Geneva. All persons who by their professions are concerned in the preservation of health are invited, and, though the great majority of members are medical men, sanitary engineers, architects, and functionaries engaged in carrying out sanitary and factory legislation also hold a prominent place in the Congress. The Dutch Minister of the Interior will be the honorary president. An influential committee of organisation has been constituted, as also a committee to assist in procuring lodgings, and another to organise fêtes. In the afternoons general assemblies will be held, at which eminent sanitarians will read papers on suitable subjects. First among these we note the name of M. Pasteur, who will resume the question of the Attenuation of Virus. Professor Koch, of Berlin, is expected to speak on Infectious Diseases; and Dr. Finkelnburg, of Bonn, will read a paper on the Practical Application of the Doctrine on Virus. Dr. W. H. Corfield, of London, has a paper on "Science the Enemy of Disease." The sections, five in number, will meet in the mornings. These are divided as follows:—1st Section. General and international hygiene and prophylaxis. 2nd. Sanitation of town and country, public drainage, roads, disposal of refusal, cremation, &c. 3rd. Individual hygiene, food, clothes, house accommodation, education, gymnastics, &c. 4th. Unwholesome industries. 5th. Demography or sanitary statistics. Altogether there is every reason to believe that the Congress will be a success. The Dutch are essentially a hospitable people, and already an excursion is arranged for the Sunday to Rotterdam and Fyenoord, &c. Foreign governments are invited to send their delegates, an invitation which met with very ample response at the previous Congress held at Geneva. Of course, the English Government will not move in the matter, but by individual initiative we may easily send speakers who can worthily represent the great progress achieved in England. The official language of the Congress is French, but speeches may be delivered in other languages, subject to being summarised into French by one of the members.

PORRO'S OPERATION.

La Gazzetta degli Ospitali of May 21st reports that on the 2nd inst. Dr. Franzolini, of Sarcento (Udine), performed Porro's operation on a woman thirty-six years of age, the subject of great pelvic contraction and extensive deformities of the skeleton due to osteomalacia. The woman had been confined four times. On the last occasion she had been in labour twelve hours, the membranes had ruptured, and the fœtus had shown no signs of life for an hour. A dead male child at full term was removed by Cæsarean hysterovariotomy under chloroform. The pedicle was treated by the extra-peritoneal method and clamped. Progress was favourable, and the patient at the end of three weeks was reported to be fairly well (*assai bene*).

OUTBREAK OF SMALL-POX IN HULL.

AT a recent meeting of the Sanitary Committee held in the Town-hall, the medical officer of health (Dr. Mason) reported that, from information received from the borough coroner, he had visited a house situated in a thickly populated part of the town, where a child aged eighteen months had died from confluent small-pox, without having been attended by a medical man, whereby the nature of the disease was not known until after death. The mother stated that she had taken the child to a local chemist, who had treated it for measles. During the child's illness three other children of the family had been attending the Roman Catholic schools, and since that time they and seventeen other children attending those schools, fifteen girls and two boys, whose ages varyied from six to eleven years, had been admitted into the Borough Hospital suffering from small-pox. They had all been taken ill on or about the same date, and had been in the same classes as the children of the family first attacked. Three of the children were unvaccinated. The others have had comparatively mild attacks, illustrating the protection ensured by vaccination; and it is a remarkable fact that the younger children in the schools have more or less escaped the infection, although equally exposed with the elder ones. No death from small-pox has occurred among vaccinated persons during the epidemic. Immediately the outbreak became known the schools were closed, and they and the chapel in connexion with them were fumigated and cleansed. Other cases of small-pox are directly traceable to this source. A young man, engaged in a pawnbroker's shop, contracted the disease in the pursuit of his ordinary business. The shop was visited, and every care seemed to have been taken to separate parcels deposited from infected houses, the whole premises being thoroughly fumigated. In every house where small-pox has made its appearance a system of

thorough disinfection, by the fumigation of the rooms and the stripping and limewashing of the walls, has been carried out. Every care has been taken to prevent the spread of the disease, and bills stating the precautions to be taken against small-pox, with disinfectants, have been freely distributed in the neighbourhoods where the disease is located. A hospital tent has also been erected for the better treatment of patients suffering from small-pox, and with this additional accommodation, and the assistance of the large and efficient staff Dr. Mason has at his disposal, there is every hope that the disease will soon be stamped out, especially if the public will protect themselves by revaccination.

MR. SHIRLEY MURPHY draws the attention of the vestry of St. Pancras to the fact that a house-to-house inspection is revealing the existence of a large number of unvaccinated children in the parish; and regarding as he does the present prevalence of small-pox in the metropolis as an indication of a probable and much wider outbreak in 1885, he presses for joint action with the guardians to secure more efficient primary vaccination and re-vaccination. He also reminds the vestry of a power which is not sufficiently resorted to. Where a Poor-law medical officer is attending a case of small-pox, and the patient is a pauper, that officer is permitted to charge the guardians with the fees for the vaccination and revaccination of persons resident within the house in the same way as if he were a public vaccinator. If this provision of the Vaccination Act, 1871, were more frequently carried out, an important step towards preventing the spread of small-pox would be taken.

FROM the report of the examination made by Colonel Sir Francis Bolton of the water supplied by the several metropolitan water companies during the month of April, it appears that the Thames water sent out by the Chelsea, West Middlesex, Southwark, Grand Junction, and Lambeth companies contained, for river water, only a small proportion of organic matter, and was in this respect much superior to that distributed in the previous month of this year. With the exception of the Southwark Company's water, which was slightly turbid, and that of the Lambeth Company's, which was very slightly turbid and contained moving organisms, all the samples were clear and bright. The water drawn from the Lea and distributed by the New River and East London Companies was superior to any of the Thames waters.

FROM the report on the composition and quality of daily samples of the water supplied to London for the month ending April 30th, issued by Messrs. Crookes, Odling, and Tidy, it appears that the general excellence in character of the water supplied during the previous quarter has been more than maintained by the supply of the past month. Of the 161 samples of water examined, the whole were, without exception, well filtered, clear, and bright. Their aeration was abundant; and in respect to degree of freedom both from colour and organic matter, their condition was wholly satisfactory.

THE whole of the medical staff of the Hospital for Sick Children, Sydney, have resigned their appointments. The cause assigned in the letter of resignation is the non-compliance on the part of the committee with certain recommendations, the carrying out of which the medical staff regarded as essential to the well-being of the inmates of the institution.

THE Medical School of St. Mary's Hospital has just made a valuable addition to its teaching staff in the person of Dr. Crichton Browne, who has accepted the lectureship on Mental Diseases.

AT the Prince Alfred Hospital, Sydney, on Feb. 27th, Mr. Foreman, obstetric medical officer, extirpated per vaginam the whole of the cancerous uterus of a woman aged forty. The patient made a good recovery. The *Australian Medical Gazette* will probably publish a full report of the case, which, our contemporary believes, is the first of the kind performed in South Australia.

WE understand that Her Majesty has been pleased to accord her assent to the proposal made by us that a wing of the new building of the National Hospital for the Paralysed and Epileptic, Queen-square, should be named after the late Duke of Albany, as a memorial of the much-lamented Prince.

THE first open Surgical Scholarship of the Society of Apothecaries of London has been awarded by the Society, on the recommendation of the Examiners, Thomas Bryant, Esq., and Sir William Mac Cormac, to Sidney Plowman, St. Thomas's Hospital.

THE Bill which Lord Redesdale has introduced with reference to pigeon-shooting is intended to check the practice of mutilating or otherwise maltreating the birds so as to affect their power of flying after being liberated from the traps.

THE first sitting of the commissioners appointed to inquire into the Queen's Colleges and the Royal University of Ireland will take place in Belfast about the 3rd proximo; but whether the proceedings will be open to the public has not yet been definitely stated.

DR. EMMERICH of Munich believes that he has discovered the cause of an epidemic of inflammation of the lungs, during which 161 persons were attacked, by finding the peculiar micro-organism of the disease in the plaster of the walls and ceilings of the infected houses.

THE HEALTH EXHIBITION.

SOME little time must pass before the immense International Exhibition at South Kensington is in perfect order, and hundreds of workmen are still busy upon it, but, thanks to the unremitting labour of all concerned, the great mass of the work has been accomplished, and one of the most interesting and valuable of the successors to the Great Exhibition of 1851 is so far advanced that in some departments, at any rate, a critical study is already possible. It will be our duty, as time goes on, to comment on articles exhibited in almost every one of the departments; and although it will obviously be impossible to notice all even of the novelties exhibited, we shall endeavour to find some word for everything, old or new, that appears of paramount importance.

The Executive Committee have wisely given a very wide meaning to the word Health. To make the Exhibition a success it was evidently necessary to render it attractive, and this could not have been done without the inclusion of much that affects public health only in an indirect manner. Thus we have not only food and sanitary appliances in endless variety, but educational and decorative appliances, including under the latter head not a little high art. Of course, in the widest sense, whatever contributes to the enjoyment of life and to the cultivation of healthy tastes tends towards health. There is some kind of justification for almost everything in the collection, miscellaneous though it is; but, on the other hand, we fail to see on what grounds medical and surgical appliances have been excluded from the show. Surely they contribute as much to the preserva-

tion of health as, let us say, globes, sewing machines, or models of old London houses.

The arrangement of the grounds and buildings has been managed with wonderful skill. Necessarily it is very complex, and we advise anyone whose time for inspection is limited to get some friend who knows the place to act as guide. It takes quite a day to learn one's way about, and even after many visits discoveries of interesting and important exhibits are constantly occurring. The chief cause of this difficulty is, of course, the impossibility of bringing the whole of each class under one roof. The larger articles have to be placed in the grounds, sometimes at great distances from the rest. Inconvenient crowding of the articles has been avoided almost everywhere, and, except perhaps at a few popular points, locomotion will probably be easy. The height and careful ventilation of the buildings rendered them pleasantly cool even in the recent hot weather. Of the lighting arrangements we will not at present say more than that they seem satisfactory, and are certainly interesting. They require more study than we have yet given them. An excellent feature is the number of withdrawing rooms scattered about the place, and another is the pretty and convenient drinking fountains which occur at intervals.

The Commissariat Department of the Exhibition is so various and so scattered that we have not yet thoroughly mastered it in all its details. The main bulk of the work falls, as in the Fisheries Exhibition, upon Messrs. Bertram and Roberts, who seem to have excelled themselves in economy and quality. The large first-class dining-rooms seem much as they were last year. Then the dinners, both cold and hot, were excellent and fairly moderate in cost.

In another room in the great South Gallery, the School of Cookery provides a shilling dinner of three courses. We confess to some disappointment in regard to this dinner. Perhaps we were unlucky, but on the day of our visit the *menu*, though fairly good, was not remarkable in any way, and the service was insufficient. Professors of the culinary art should try to avoid the too familiar rumpsteak pie, potatoes, and very plain pudding, and should endeavour to furnish their visitors, particularly their lady visitors, with ideas by which to vary the necessary monotony of the domestic banquet. Probably they will accomplish this when they have got into full working order. Meantime we may suggest that there ought to be more than one overworked boy to fetch beer and claret. We have not tried the sixpenny fish dinner, which we hope is a shade more substantial than that of last year, or the sixpenny vegetarian dinner. The last is spoken well of by the courageous few who have tried it. We hope, or at any rate intend, to join the devoted band before long.

As to lighter refreshments, they may be obtained in a variety of places. Glasses of milk are sold at the dairies, and tea and coffee at pretty little rooms and arbours, close to the gardens. We were most struck with Sir Philip Cunliffe Owen's coffee-house on the north side of the South Gallery. A coffee machine of special construction has been adopted by Sir Philip, in which freshly roasted and ground coffee is infused. The chief peculiarity of the machine is that the infusion passes through two finely perforated metal strainers, which render it as bright as brown sherry. This delicious coffee is sold in good-sized cups, with a plate of biscuits, for twopence. At a large stall by the Eastern Annexe, Messrs. Etzenberger supply good clear coffee (with chicory) for a penny a cup. Why do not coffee taverns manage as well? The coffee sold in most of them is simply disgusting.

THE SCHOOL.

We must confess to a feeling of disappointment on visiting the department set aside for exhibits relating to the School, and in a less degree with regard to the division for Educational Works and Appliances. When it was first announced that school hygiene was to form a special feature of the present Exhibition, it was hoped that some of the chief public schools, or leading educational establishments, would have sent illustrations of the arrangements for studies, dormitories, lavatories, school furniture, &c., adopted by them. Had this been done, it would have afforded an excellent opportunity for contrasting the different systems employed, and also a basis on which estimates might be formed as to the best system to be adopted in special circumstances. For instance, a difference of opinion exists with regard to the management of studies—whether these should be altogether separate, or consist of a small study for one or two inmates, or parlour-study to hold six or eight; and as to dormitories, whether they shall be subdivided into cubicles, or be allowed to remain without subdivision. Another very important question is the best means of keeping the privies, latrines, &c., distinct from the school buildings, and yet at the same time so connected with them that the scholars are not exposed when using them in bad weather or in the night-time. This latter problem is rarely solved successfully, but the nearest approach to it we have found was in a house at Rugby, belonging, if we remember right, to the second master, the Rev. W. Arnold. Here by a very simple contrivance the closet was completely shut off from the house during the day, whilst at night or during bad weather access could be had to it without the slightest exposure, or without the risk of sewer-gas passing into the house. All these are subjects which would have afforded numerous points for contrast and instruction, but unfortunately they are very imperfectly represented in the Exhibition, those that are shown being chiefly models of improved buildings for elementary schools, infant schools, and crèches.

One reason which may account for much of the disappointment felt on entering the School Department is that it has been unnaturally divorced from the Educational Department, the former being placed in the East Central Gallery, whilst the space set apart for exhibits in education are placed at the top of the Royal Albert Hall. This is unfortunate, since the apparatus and fittings, if not the models and appliances required for teaching in schools, ought certainly to be exhibited in connexion with the arrangement of school buildings. Indeed, it appears to us that a great opportunity has been lost. The large space set aside for the purpose of school exhibits, and which struck us on entering as being exceedingly bare, might have been broken up into a series of sections to represent the plan of some typical school, decided upon by the committee, showing portions of a school-room, a study, a dormitory, out-door premises with gymnasium, and arrangements for latrines. Each of these divisions could then have been fitted with their special sanitary and educational appliances. Thus, for instance, in the school-room might have been exhibited the various forms of desks, seats, and teaching apparatus. In addition to these, the room might have been fitted with various kinds of heating, lighting, and ventilating appliances. In the same way a dormitory might have been shown under the cubical, contrasted with the open, system. And here an opportunity could have been afforded of exhibiting the most useful kind of dormitory furniture, arrangements for storing and hanging clothes, and also different kinds of lavatories and bath-rooms. In the dining-hall, appliances for serving the meals, and the methods adopted for keeping the food hot during distribution, and many of those arrangements that are necessary for serving the food in a palatable and appetising form, might have been shown; whilst between the dining-hall and the passage to the playground might have been exhibited models of school cloak-rooms, &c. To these could have been added a ward from the sick-house, showing the special details of its construction and arrangements, also the apparatus required for disinfection, with printed rules regarding the management and isolation of infectious cases, the arrangements made for nursing, and many other particulars which would have been of considerable interest, especially to medical officers of schools. Similarly with respect to the closets, privies, and urinals: the out-door latrines might have been so fur-

nished that the public would have had an opportunity of contrasting the different arrangements required for each system. We are aware that many of the objects we have mentioned are on view at the Exhibition, but they are so distributed as to be of little value for purposes of comparison; and the impressions gained in the East Central Gallery become diminished in passing from it to the top of the Albert Hall.

After these remarks, it remains to draw attention to some of the most interesting of the exhibits to be found in the School Department. This, as already stated, is situated in the East Central Gallery, and such ample space has been allotted, and so little occupied, that at first sight the visitor thinks he has come upon a department in an unfinished condition. This, however, is not the case, and the vacant space seems to have been left to allow the rival trapezes exhibited sufficient room for practical demonstration. Round the walls on one side are to be seen diagrams and models, on the other side gymnastic apparatus, whilst here and there are scattered oars, sculls, paddles, bats, balls, stumps, leg guards, Indian clubs, and other athletic accessories. In the centre a few cases and models are distributed, which somewhat relieve the general barrenness. The School, at this department is called, consists of seven classes. The first (Class XXXIV.) is set aside for designs and models of improved buildings for elementary schools, infant schools, and crèches. This group is sadly disappointing with regard to its extent, but the exhibits (nine in number) that are shown are apparently careful reproductions to scale of existing buildings. The Dutch designs (1274), sent by the Mayor of Leyden, representing the buildings of an elementary school for 372 pupils, and designs for school furniture, are well worth close and attentive study. The next (Class XXXV.) is set aside for the exhibition of apparatus and fittings for warming, ventilating, and lighting schools, and for latrines, closets, &c. The general effect, however, is considerably diminished owing to most of the exhibits not being located in this department, but having to be sought for in other parts of the buildings. And here we must complain of the very inadequate cataloguing; for example, we are referred for domestic engineering and sanitary appliances from this class to Class XXIII. In referring to this in the catalogue, we find that we have to visit the East Annexe, but no indication is given as to where we shall find the exhibits of a particular firm, and we have to look through perhaps the whole of the exhibits in this class before we come to what we want. To make the reference complete, the number (566) of the exhibit, or of the page (63), should have been given as well as the class referred to. In some instances even the class is not given, but merely "See machinery in motion." As the exhibits in this department are numerous, and as the exhibitors' names are not arranged in alphabetical order, it is a matter of extreme difficulty to find the apparatus or appliance referred to. All this trouble and inconvenience might have been obviated by merely attaching, as we have suggested, the official number of the exhibitor's name to the reference, and we hope that some such system will be adopted in any fresh issue of the catalogue. Among the exhibits in their proper place in this class, the model (1282) of the warming and ventilating apparatus of the City of London School, by Messrs. Herring and Son, is one of considerable interest, and is a system which appears to be particularly suited for schools of that class. A. B. Reck of Copenhagen (1279) exhibits some heating and ventilating stoves and hot-air furnaces for schools, infirmaries, churches, &c., that struck us as being exceedingly well adapted for the various purposes for which they are designed. In Class XXXVI. there are only two exhibits: one a model (1285) by the Rev. E. M. MacCarthy, of King Edward's School, Birmingham, of a cloak-room adapted from the best examples to be found in American public and normal schools, showing drying apparatus, drainage of umbrellas, &c., and which is now in use at Mr. MacCarthy's school at Birmingham; the other, by Clements, Jeakes, and Co., which, however, is not to be found in this department, but in Class XXIV. in the East Quadrant (611), who exhibit an improved method of drying clothes and an improved ventilating cupboard. We are surprised that more exhibits have not been attracted to this important class, the special fittings for storing and drying clothing at large establishments being a matter of considerable importance both for health and comfort. Class XXXVII. exists only in name, the exhibits which refer to school kitchens, school canteens, methods of warming food, &c., being distributed in the Western Gallery and in the East Quadrant. In this department, Clements, Jeakes, and Co. (611) exhibit a set of apparatus for school canteens, and also an appliance for warming children's meals; Newton Chambers (596), East Quadrant, exhibit a hot closet with steamers; Wilson and Co. (604) show an extremely useful form of patent hot closet and carving dishes combined. We were surprised to find this firm's name omitted in Class XXXVII., for though the closet is chiefly designed for the use of hotels and restaurants, still it is also extremely serviceable for large schools, where it is a matter of considerable importance that the food should be served hot from the kitchen.

The class reserved for the exhibition of special apparatus for physical training in schools is undoubtedly the most complete feature of this department. An interesting collection of rowing appliances (1290) is exhibited by Edward Ayling, of Vauxhall, and athletes will be able to compare the form of sculls used by modern champions with the racing scull of a century ago. James Lillywhite worthily represents the cricket department, General gymnasia with their fittings are exhibited by Piggott Brothers, George Spencer, Adolf Stempel, and Oscar Knofe. Among these we would specially draw attention to the "nursery gymnasia" (1299 and 1301) exhibited by Piggott Brothers and George Spencer respectively; and the "portable gymnasium" on the German movable system (1304) by Adolf Stempel, and the "lawn gymnasia" (1307) exhibited by Oscar Knofe. Special apparatus for the development of various parts of the body and for the correction of deformities are exhibited by the Zander Medico-Gymnastic Company, and by Dr. Roth of Wimpole-street. The diagrams of the latter, showing how bad positions during the time of education have a tendency to induce lateral curvature and other complaints, ought to be studied carefully by parents and school masters. In short, this class is replete with interest, and in a great measure redeems the whole department from the reproach of failure.

Had a little more pains been spent in organising the arrangements, the School might have been the most interesting as well as the most instructive department of the Exhibition, instead of being apparently subsidiary to other departments. In the group reserved for educational works and appliances, which we shall consider in a future article, the organisation is more complete, and therefore more available for the purposes of instruction; had the two divisions been grouped together they would, however, have gained both in importance and general interest.

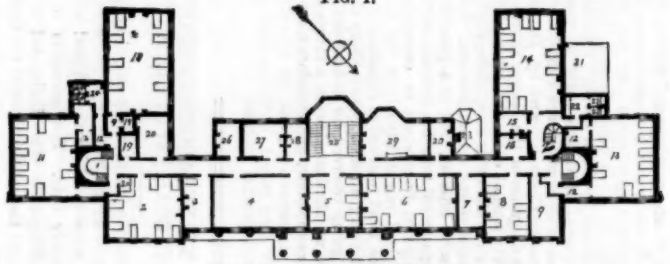
ALTERATIONS AND ENLARGEMENTS OF THE HULL GENERAL INFIRMARY.

ATTEMPTS to improve the bad planning and arrangements of existing hospitals have not generally been successful, and especially so in those cases in which the original buildings were erected at an early date. The managers of these institutions are in consequence often indisposed to make extensive alterations, and they prefer to await the accumulation of funds sufficient for entirely pulling down and re-erecting the buildings upon modern principles; and under certain circumstances this may be a wise policy. More often, however, than not it is found impossible to raise the amount required within a reasonable period; and the growing necessities of a surrounding district then compel the expenditure of the money as it is collected in enlargements and alterations intended to be of a temporary character, and therefore not carried out under skilled advice or upon any properly devised plan. And thus it is that so many examples exist of hospitals the planning and sanitary arrangements of which are of so discreditable a character as to give rise to the statement that more diseases arise inside these buildings than are brought into them from the outside.

The following account of the growth of the buildings of the Hull General Infirmary and the more permanent alterations now about to be effected there will afford a good illustration of the evils arising in the past from the temporising policy referred to above, and of the advantages to be derived from the adoption of an opposite course. The

HULL GENERAL INFIRMARY AS ALTERED AND ENLARGED.

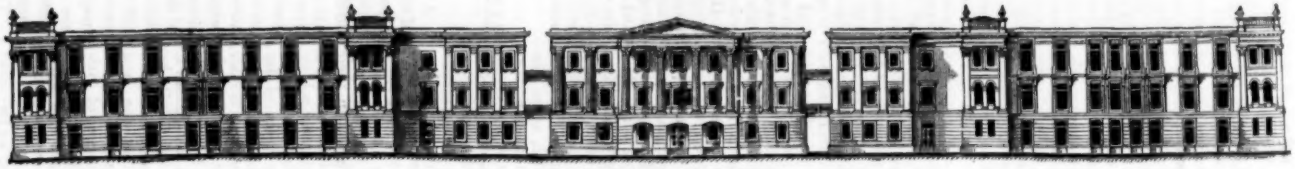
FIG. 1.



Plan of First Floor before Alteration.

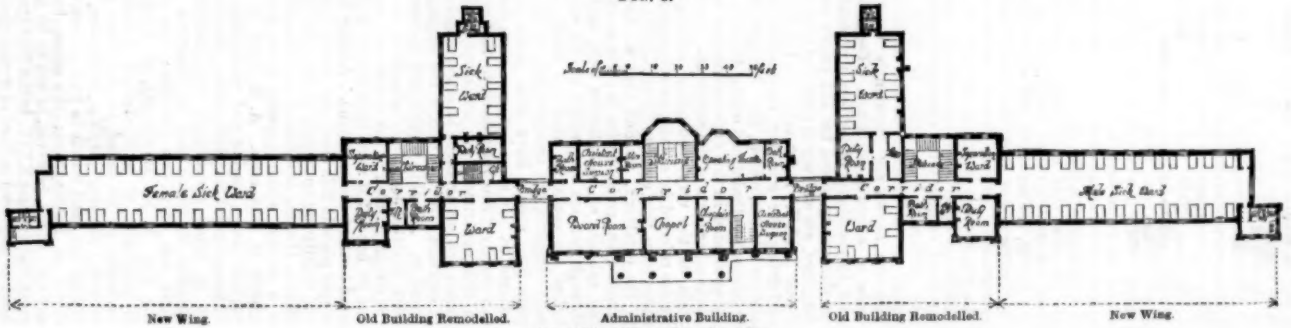
Nos. 1, 10, 25	Staircases.	Nos. 21	Roof of operating-room.
,, 2, 3, 5, 6, 8, 11, 13, 14, 18	Sick wards.	,, 22, 24, 24A	Waterclosets, slop-sinks, lavatories.
,, 4	Chapel.	,, 23	Roof over physicians' consulting-room.
,, 7, 9, 28	Officer's bedroom.	,, 26, 30	Bath-rooms.
,, 12, 17, 19	Passages, lobbies, closets, &c.	,, 27	Assistant house-surgeon's bedroom.
,, 15, 16, 20	Duty-rooms.	,, 29	Operating theatre.

FIG. 2.



Front Elevation as Altered.

FIG. 3.

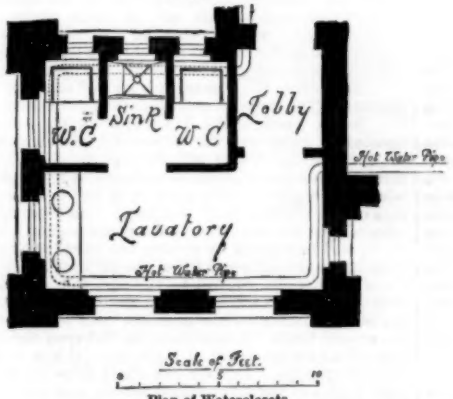


New Wing. | Old Building Remodelled. | Administrative Building. | Old Building Remodelled. | New Wing.

Plan of First Floor after alteration.

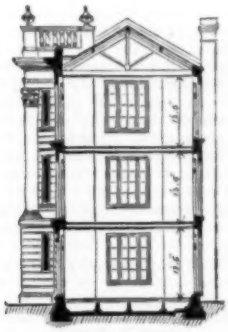
HULL GENERAL INFIRMARY.

FIG. 4.



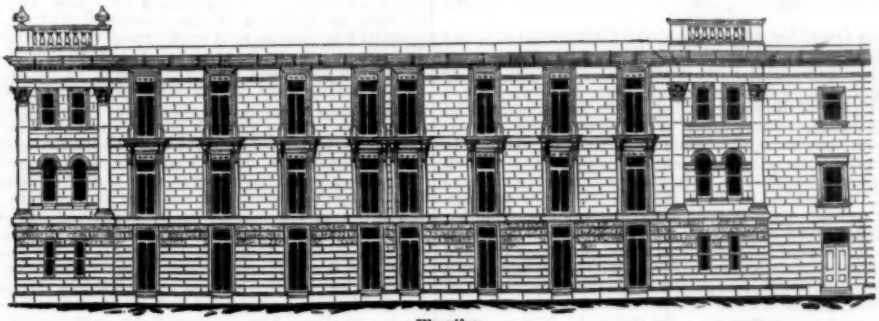
Plan of Waterclosets.

FIG. 5.



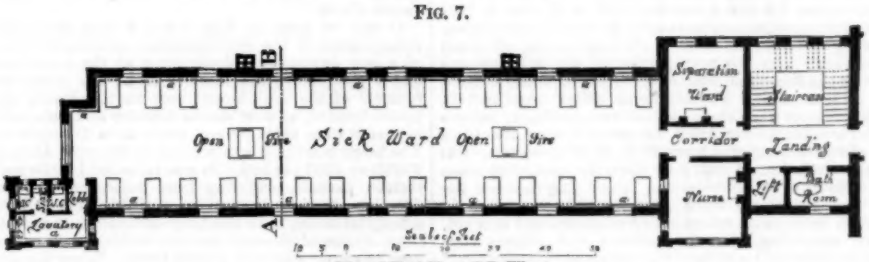
Section on line A B.

FIG. 6.



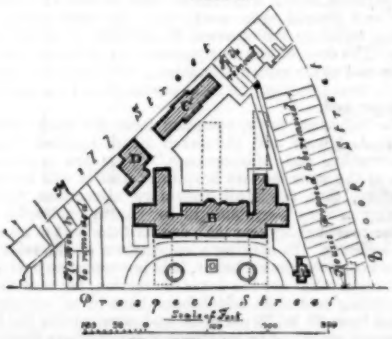
Elevation.

FIG. 7.



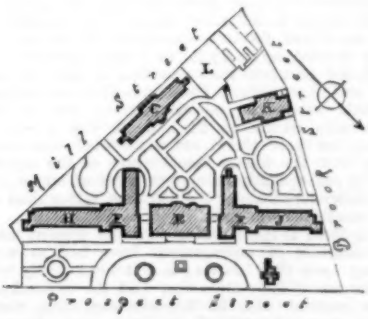
Plan of First Floor, S.E. Wing.

FIG. 8.



Plan of Site at present.

FIG. 9.



Plan of Site as altered.

A. Porter's lodge and entrance gates. B. Present main building. C. Infectious wards altered to nurses' home. D. Washhouse and mortuary. E. Administration offices. F F. Sick wards remodelled. H J. New sick wards. K. Out-patients' department. L. New washhouse and laundry. a. Hot-water pipes next walls.

1884.

New Wing.

Old Building Remodelled.

Administrative Building.

Old Building Remodelled.

Plan of First Floor after alteration.

New Wing.

present board of management find themselves possessed of a building that was as originally constructed (100 years ago) a fairly good example of the old style of corridor hospital construction, but which in the course of years has been so injudiciously altered and enlarged that Dr. Hagyard, the house-surgeon, found it necessary in his medical report of last year to draw attention to the fact that although "a great number of deserving cases had to be sent away for want of room and for fear of overcrowding the institution and rendering it insanitary," yet there had been "a great deal of sickness among the resident officials, nurses, and servants, principally of a kind pointing to insanitary conditions of the hospital;" and further he points out that, on the contrary, the night nurses, who for want of space in the main building are located in one of the adjoining houses in Brook-street, "have been singularly free from sore-throats and other septic ailments." Under these circumstances the usual course was adopted of appealing for subscriptions from the townspeople and the surrounding districts, and it was contemplated to pull down and rebuild the structure. Despite, however, the most strenuous exertions on the part of the board, headed by its energetic chairman, Mr. Henry Simpson, it was found impossible to raise a sufficient amount for this purpose, and so it was ultimately determined to take the best means possible of permanently improving the arrangements of the present building and enlarging it to accommodate the constantly increasing numbers of applicants for admission.

Before describing what these works are to consist of it may be well to give a short account of the previous enlargements of the buildings, for it fairly illustrates errors which, it may be hoped, will be avoided in any future hospitals. Fig. 1 shows a plan of the principal floor of the building as it at present exists, so numbered as to indicate the various additions that have been made from time to time. The original building contained accommodation for seventy inmates, and consisted of three storeys of rooms, numbered from 1 to 10, ranged along the principal front and connected together by means of a corridor running along the back front. The building was first opened on Sept. 1st, 1784. In the year 1842 the wings containing the wards and offices numbered upon the plan from 11 to 13 were added, and so far the building was as good a hospital as any erected at that date, and before the introduction of the pavilion or block system of construction. But the work of deterioration shortly afterwards began—first by the erection in 1858 of a wing containing the rooms numbered 14 to 17, then in 1853 the commencement, and subsequently in 1864 the completion, of the wing containing Nos. 18 to 20, thus cutting off much of the sunlight from the rear portion of the building and destroying the free circulation of air that previously existed around all parts of it. The additional offices numbered 21 to 24 on the plan were also added at various times; but the climax of injudicious extension was reached when the three storeys of rooms numbered from 25 to 30 were erected, thus effectually closing in on each floor the only ventilated sides of the corridors of communication. The living rooms of the officers and the wards containing the sick now open in common on to the same unventilated passages, and it is not, therefore, surprising that the patients and officers thus huddled together are found to be the victims of "hospitalism," as stated in the medical report above referred to. It is, however, not only in the general planning of the extensions above referred to that errors have been committed; greater blunders occur in matters of detail. For example, the small room numbered 2A is a combined scullery and lavatory, with a washing-up sink; its only light is obtained through the glazed partition that separates it from the adjoining ward and it ventilates itself into the corridor leading to the sick wards and offices. Again, the air from the waterclosets numbered 24 and 22 also passes into the corridor, for these offices are unprovided with cross ventilation, and the higher temperature of the inside of the building consequently induces currents of air to pass from these waterclosets along the corridors rather than outwards and through the windows.

Such, then, is the building that the present members of the committee of management have had to work since entering upon their duties; and it need hardly be pointed out how many difficulties they and the medical staff have had to contend with in the administration, under such adverse circumstances, of so large and important an institution.

The first action of the committee towards the expenditure of the subscribers' donations was a consideration of the best means of enlarging the building to accommodate the increasing numbers of applicants for admission. It was at first proposed to run out at right angles from the main building one or other of the wings indicated by dotted lines at Fig. 8; but it is obvious that the adoption of either of these suggestions would only have rendered the existing defects, so far as regards air and sunlight, still more defective. The Committee subsequently called to their counsel Mr. Saxon Snell, F.R.I.B.A., and by his advice it was decided to carry out the alterations shown generally by Figs. 2 and 3. These will be seen to consist, so far as increased accommodation for patients is concerned, of two additional wings, running parallel to, and in a line with, the axis of the existing main building. The separation of the officers' quarters from their present connexion with the sick wards will be effected by cutting two gaps through the main building to the right and left of the centre of it, and removing the sick from the central to the two side detached blocks thus created. At the same time the officers' apartments and the administrative offices generally will be concentrated in the central block. Communication between the two blocks is provided for by means of light iron bridges spanning the separating gaps. But for the short arms running out at right angles to the side pavilion blocks, and which it would have been desirable to remove did the funds permit of their erection elsewhere, the building in its altered state will be as near an approach to the recognised type of English hospital construction as is possible under the circumstances. It will certainly, so far as regards the separation of the sick from each other and from the officers, be vastly superior to the arrangement of the Glasgow Western Infirmary, St. Thomas's Hospital, and many other modern institutions.

In a new building the sick pavilions would probably have been removed further from the central administration block, and the dimensions of the wards and the arrangements of their offices would have been in some respects different if unfettered by the necessity of retaining as nearly as possible the levels of the present floors, preserving the external character of the present building and other like considerations. Although, therefore, the details of the new wards (Figs. 4, 5, 6, and 7) may be taken to generally represent good ordinary hospital construction as applied to a three-storeyed hospital building, they must not be looked upon as illustrating what would be recommended were the building a new one and the designs for it unfettered by the restrictions mentioned above.

It will be seen by Figs. 8 and 9 that the plans for the enlargement of the establishment contemplate the erection of a new out-patients' department at the point marked K, and a wash-house and laundry at L; also concurrently the removal of the dead-house, post-mortem room, and wash-house from D, as well as the laundry and out-patients' department from their present position in the main building. The block marked C was erected in the year 1874, and cost £4293, or £286 per bed. It was intended for the isolation of sixteen patients suffering from infectious or contagious disorders, but in future all cases of this kind will be sent to a hospital in the town specially devoted to the treatment of those classes of diseases, and the building will consequently now be converted into a nurses' home. When the alterations have been completed the main building will accommodate 275 patients, and it is estimated that the cost of the proposed new and altered sick wards and the remodelling of the central building will amount to £25,000, or about £91 per bed. The cost of the out-patients' department, new wash-house and other minor alterations, will probably amount to £5000, thus bringing the total contemplated outlay to about £109 per bed.

The following table, compiled from the work written by Dr. F. J. Mouat and H. Saxon Snell, entitled "Hospital Construction and Maintenance," gives the actual cost of some of the more modern hospitals; and it will be obvious, therefore, that the Hull Infirmary alterations will, after allowing a very large margin for contingencies, be carried out for considerably less than one-half the cost of an entirely new building. In making a comparison of the relative cost of the hospitals, shown below, it is important to bear in mind in all cases what are the dates of erection, because the prices of building materials and labour have in all countries advanced from 20 to 30 per cent. and more within the last ten or twenty years. The buildings of the Herbert Hospital, for example, cost twenty years ago £330 per bed, but if erected now they would in all probability cost between £400 and

£450 per bed. Again, the Berlin Civil Hospital authorities state that the average rise of prices during the six years the building took to erect was 54 per cent.:—

Date of erection.	Name of hospital.	Cost per bed of buildings.	Cost per bed of land and buildings.
1860-4	Herbert Military	£330	£340
1858-65	Blackburn	286	307
1864-9	Leeds	298	326
1868-71	St. Thomas's	777	969
1870-9	Edinburgh	477	587
1871-4	Glasgow	258	318
1878	Antwerp	368	—
1869-76	Heidelberg	226	241
1868-74	Berlin Civil	351	—
1876	Halle	333	374
1853	Lariboisière	436	644
1866-76	Hôtel Dieu	1,215	2,487
1872-8	Tenon (Menilmontant)..	419	506
Not completed	Genoa	654	794
Ditto	Johns Hopkins, U.S.A.	866	—

A detailed plan elevation and section of one of the wings is shown at Figs. 4, 5, 6, and 7, and will be seen to consist on each floor of a large sick ward for thirty patients, with attached offices, a smaller separation ward for one or two patients, a nurse's room, a bath room, a lift, and a staircase. The plan (Fig. 4) of the waterclosets and lavatories was determined by the architectural character of the present building, necessitating the construction of towers or such like features at the junctions of the new buildings with the old in order to break the otherwise apparent incongruity of the windows and strings being at a different level. These features then being formed by projecting forward the duty rooms, it was desirable that similar projections should, for the sake of uniformity, be constructed at the other ends of the wings, and here therefore it was determined to place the waterclosets and lavatories. These offices are in both cases cut off from the wards, first by lobbies, and then by wide cross-ventilated and well-lighted passage ways, and they will be warmed by means of hot-water piping. Wash-hand basins supplied with hot and cold water for the use of the patients will be placed in these passages.

ASSOCIATION OF MEMBERS OF THE ROYAL COLLEGE OF SURGEONS.

A MEETING of the above Association was held on Wednesday, the 28th inst., at 3, New-inn, Strand, W.C., when a further list of members willing to act as local secretaries was submitted. A resolution was passed recording the protest of the Association at the manner in which the resolutions of the last general meeting of the Members and Fellows were ignored by the Council of the College. Other resolutions carried were to the effect that no revision of the Charter of the College will be satisfactory unless it has received the general assent of the Members and Fellows; and that another meeting of the Members and Fellows should be called to reconsider such alterations in the Charter as may be proposed by the Council. It was determined to immediately prepare a petition for presentation to the Privy Council praying that a new Charter may not be granted to the Royal College of Surgeons until due effect be given to the suggestions made at the late general meeting of Members and Fellows, and further praying that the privileges originally and justly belonging to the Members may be restored to them. A form of petition lies at the offices of the Association and at THE LANCET Office for signature.

ROYAL COLLEGE OF SURGEONS IN IRELAND.

THE annual meeting of the Fellows will be held this day (Saturday), when the following resolutions, among others, will be proposed:—

By Mr. Tagart: "That we disapprove, and condemn the conduct, of the outgoing Council, in so far as it neglected to take the steps necessary for giving effect to the resolution of the College, passed without a division on June 4th, 1883, recommending that the Fellows shall, in future, have the right of voting *in absentiâ*, by means of voting papers, for president, vice-president, and members of Council, such neglect being a practical ignoring of the expressed wish of the Fellows at large, and especially detrimental to the provincial Fellows."

By Dr. Jacob: "That the College regrets that its repeated recommendations to the Council to make arrangements for the more frequent and complete publication of the proceedings of the Council have not been carried into effect; and it, therefore, again declares its desire that without avoidable delay provision shall be made for the issue to the Fellows of a *précis* of the proceedings of the Council at least three times in the year, such *précis* to contain all motions and amendments of importance, together with the names of proposers and seconders, and of the votes of councillors thereupon in case a division has been taken. That the Council be requested, on the first occasion on which they communicate with the Fellows at large, to report to them the steps (if any) which they have taken to comply with the desire herein expressed."

Public Health and Poor Law.

LOCAL GOVERNMENT DEPARTMENT.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

Featherstone (*Urban*).—The medical officer of health of this urban sanitary district (Mr. A. Buncle) reports that in view of the exceptional rate of increase that prevailed between 1871 and 1881, when the population rose from 2265 to 5901, the usual method of estimating the present population was not available; he therefore estimates, from the number of inhabited houses on the rate-book, that the population in the middle of 1883 was 6282 persons. On this estimated population the birth-rate last year was 44·8, and the death-rate 17·9 per 1000. The birth-rate was considerably lower than in any of the six preceding years, and the death-rate was 2·5 per 1000 below the mean rate in the six years 1877-82, and lower than in any of those years except 1881, when it was 16·4. If the death-rate were corrected for the abnormal age distribution of the population, which contains an exceptionally large proportion of young adults and an exceptionally small proportion of elderly persons, it would not appear quite so favourable. The death-rate from the principal zymotic diseases was equal to 4·2 per 1000, against 2·2, the mean rate in England and Wales, and 3·5, the mean rate in the district in the six preceding years. The 27 deaths from these zymotic diseases included 13 from whooping-cough, 5 from scarlet fever, and 4 from diphtheria. With reference to the prevalence of zymotic disease and its relation to sanitary condition, Mr. Buncle points out that during the past three years the zymotic death-rate has averaged 9·9 per 1000 in Loscoe, where serious defects of sanitary condition have from time to time been pointed out by the medical officer of health. Radical improvements in the sewerage of this part of the district are now in progress. The rate of infant mortality in the whole district was equal to 17·3 deaths under one year to 100 births, against 13·7 in all England. This excess was in some measure due to the fatality of whooping-cough. The medical officer of health, in concluding a practical and excellent report, draws the following moral from his local experience:—"However much we ameliorate the condition of a place by constant looking after, it availeth little if there is a continuance of bad drainage, bad water, and surroundings that cannot be otherwise than a nuisance." It may be hoped that the sanitary authority of this district will, under the influence of this report, lose no time in carrying out the more urgent recommendations of their medical officer.

King's Norton Rural District.—The reduction which has taken place in the mortality in this rural district is most satisfactory. In the seven years ending 1880 the death-rate averaged some 17·6 per 1000, whereas in 1881 and 1882 it did not much exceed 13, and in 1883 it had fallen to 11·7. The zymotic death-rate has also been exceptionally low, and Mr. F. Hollinshead is justified in drawing the conclusion that these statistics go to prove the value of the adoption of proper sanitary measures. The statistical reference to the deaths under one year of age is not quite clear; the rate

was however low, reaching 9·7 per cent. of the registered births. A farmhouse has been taken as an infectious hospital, and it was supplemented during a prevalence of small-pox by a Doecker hospital tent, a form of accommodation which will be found of considerable use as a means of adding temporarily to an already existing hospital or administrative building. Sewers have been completed in Northfield, and it is to be hoped that, when the house-connexions are made, through-ventilation of drains will be insisted on. Where wells are subject to risk of contamination, measures are taken to secure their closure, and this is the more easy since the mains of the Corporation of Birmingham now run through the most populous parts of the district.

Bath Rural District.—It is satisfactory to note the diminution in the mortality of places like Twerton, a locality lying on a damp subsoil near the river, the more so as Dr. Harper is able to attribute it, to a great extent, to the care which is bestowed on the provision of dwellings, all plans being now carefully examined with a view to the enforcement of the model bye-laws. Twerton has, however, one important sanitary defect; it still resorts to wells which are liable to pollution, and this notwithstanding the fact that the mains of the Bath Corporation run through the district. The sewage befouled river tends, especially during flood time, to saturate the soil in which the wells are sunk, and no such lesson as the occurrence of twenty cases of enteric fever in one row of villas should be needed in order to secure the closure of wells in this now populous suburb. The experience, although now so common, as to the advantages of a proper infectious hospital is worth noting. Dr. Harper says he has no difficulty in persuading parents to send their children there; in fact, it appears to be in such good repute that the children think it a hardship to be compelled to leave it. Excellent sanitary work is being carried on in this district generally.

Carnarvon Combined Districts.—Mr. Hugh Rees reports some wide prevalences of infectious diseases, and notably of scarlet fever, which caused forty-one deaths in the Carnarvon and Bangor urban districts. The question of the provision of means of isolation he describes as being at a dead-lock. The local authorities, he says, hesitate to incur the expense of building hospitals unless they have prompt information as to the existence of infectious diseases in their district, and the central authority refuses to grant powers as to compulsory notification unless the local authorities show that they have the means of checking it when it is brought to their knowledge. It seems to us that sanitary authorities who are in earnest as to this matter should show that they are so by providing the needed means of isolation, for such accommodation has, quite apart from compulsory notification, led to the prevention of many an outbreak of disease. Our reference above to the Bath rural district may be noted in this connexion. In the Bangor and Beaumaris rural sanitary district typhoid fever has been unusually prevalent, and it has apparently been due to traces of the so-called Bangor epidemic still operative in the district. In Bangor borough itself, however, the disease has hardly shown itself, and Mr. Rees attributes this result in part to the constantly maintained disinfection of the sewers, which have been periodically charged with euchlorine gas. The water-supply of Colwyn Bay, which had been the subject of much complaint, has been remedied as the result of extensive alterations effected by the water company, and many other improvements have been carried out in different parts of the district.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In twenty-eight of the largest English towns 5959 births and 3343 deaths were registered during the week ending the 24th inst. The annual death-rate in these towns, which had been equal to 22·7, 21·8, and 21·1 per 1000 in the three preceding weeks, further declined to 19·9 last week, and was lower than in any previous week of this year. During the first eight weeks of the current quarter the death-rate in these towns averaged 21·7 per 1000, against 22·1 and 22·9 in the corresponding periods of 1882 and 1883. The lowest rates in these towns last week were 10·9 in Birkenhead, 14·8 in Bristol, 16·7 in Salford, and 16·9 in Leicester. The rates in the other towns ranged upwards to 27·6 in Plymouth, 27·8 in Preston, 28·0 in Halifax, and 28·1 in Oldham. The deaths referred to the principal zymotic diseases in the twenty-eight towns declined last week to 497, and were fewer than in any week since the end of March; they included 156 from measles, 138 from whooping-cough, 68 from scarlet fever, 46 from diarrhœa, 37 from "fever" (principally enteric), 28 from diphtheria, and 24 from small-pox. No death from any of these diseases was recorded last week in Halifax, whereas they caused the highest death-rates in Plymouth, Wolverhampton, and Portsmouth. Measles caused the greatest mortality in Oldham, Plymouth, and Wolverhampton; whooping-cough in Liverpool and in London; scarlet fever in Newcastle-upon-Tyne and Cardiff; and "fever" in Norwich and Blackburn. The 28 deaths from diphtheria in the twenty-eight towns included 19 in London and 4 in Nottingham. Small-pox caused 22 deaths in London (including 5 recorded in the *Atlas* hospital ship moored in the Thames off Dartford, outside Registration London), 3 in Sheffield, 2 in Liverpool, and 1 both in Derby and Sunderland. The number of small-pox patients in the metropolitan asylum hospitals, hospital ships, and camp hospital, which had increased in the nine preceding weeks from 148 to 735, further rose last week to 924, and exceeded the number under treatment at any time since July, 1881; 232 new cases were admitted to these hospitals during last week, against 266 and 112 in the two previous weeks. The deaths referred to diseases of the respiratory organs in London, which had been 360, 326, and 295 in the three preceding weeks, further declined to 261 last week, and were 27 below the corrected weekly average. The causes of 86, or 2·6 per cent., of the deaths in the twenty-eight towns last week were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Birmingham, Leicester, Portsmouth, and in four smaller towns. The largest proportions of uncertified deaths occurred in Halifax, Bradford, and Preston.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been equal to 24·9 and 24·5 per 1000 in the two preceding weeks, further declined to 22·3 in the week ending the 24th inst.; this rate, however, exceeded by 2·4 the mean rate during the same week in the twenty-eight large English towns. The rates in the Scotch towns last week ranged from 16·5 and 18·3 in Greenock and Dundee, to 25·7 in Glasgow and 25·9 in Paisley. The deaths in the eight towns included 88 which were referred to the principal zymotic diseases, against 94 and 93 in the two preceding weeks; 33 resulted from whooping-cough, 13 from "fever," 13 from diarrhœa, 12 from measles, 9 from diphtheria, 7 from scarlet fever, and one from chicken-pox, which, in accordance with a system of classification long since abandoned in England and Scotland, the Scotch authorities persist in classing to small-pox. The rate from these diseases averaged 3·6 per 1000 last week in the Scotch towns, and was 0·6 above the rate from the same diseases in the twenty-eight English towns. The 33 deaths from whooping-cough in the Scotch towns showed a decline of 8 from the number in the previous week, and included 18 in Glasgow, 4 in Edinburgh, 6 in Aberdeen, and 3 in Dundee. The 13 deaths referred to "fever" showed a marked increase upon recent weekly numbers; 4 were recorded in Edinburgh, 4 in Leith, and 3 in Glasgow. The 13 deaths attributed to diarrhœa also showed an increase, but were two below the number in the corresponding week of last year. The fatal cases of measles, which had been 17 and 13 in the two previous weeks, further declined to 12 last week, of which 4 occurred in Leith, 3 in Dundee, and 2 both in Glasgow and Edinburgh. The 9 deaths referred to diphtheria exceeded the number in the previous week by 2, and included 4 in Glasgow, 2 in Edinburgh, and 2 in Aberdeen. Five of the 7 fatal cases of scarlet fever occurred in Glasgow. The deaths referred to acute diseases of the respiratory organs in the eight towns, which had been 148 and 100 in the two previous weeks, further declined to 98 last week, and were so many as 51 below the number returned in the corresponding week of last year. The causes of 89, or nearly 17 per cent., of the deaths in the eight towns were not certified.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had been equal to 31·8 and 25·7 per 1000 in the two preceding weeks, further declined to 23·8 in the week ending the 24th inst. During

the first eight weeks of the current quarter the death-rate in the city averaged, however, 27·9 per 1000, whereas it did not exceed 20·6 in London and 22·2 in Edinburgh during the same period. The 160 deaths in Dublin last week showed a further decline of 13 from the high number returned in recent weeks, and included 12 which were referred to the principal zymotic diseases, against 11 and 18 in the two previous weeks; of these 4 resulted from "fever," 3 from scarlet fever, 2 from diphtheria, 1 each from measles, whooping-cough, and diarrhœa, and not one from small-pox. These 12 deaths were equal to an annual rate of 1·8 per 1000, the rate from the same diseases being 3·5 in London and 2·7 in Edinburgh. The 4 deaths from "fever" corresponded with the number in the previous week, while the 3 from scarlet fever showed a decline of 5; the 2 from diphtheria make 5 from this disease during the current quarter. The 5 deaths from violence exceeded the numbers in recent weeks; and 57 deaths were recorded in public institutions, 21 more than those in the previous week. The deaths of infants showed a marked decline, while those of elderly persons were somewhat more numerous. The causes of 13, or nearly 8 per cent., of the deaths registered during the week were not certified.

THE SERVICES.

ARMY MEDICAL DEPARTMENT.—Surgeon-Major James Paxton, M.D., to be Brigade Surgeon, vice C. M. Jessop, granted retired pay; Surgeon-Major Fitzgerald Edward Scanlan to be Brigade Surgeon, vice J. Watts, granted retired pay.

ADMIRALTY.—Staff Surgeon Henry Charles Woods, M.D., has been promoted to the rank of Fleet Surgeon in Her Majesty's Fleet; Fleet Surgeon Edward Higgon Evans has been placed on the Retired List, with permission to assume the rank and title of Deputy Inspector-General of Hospitals and Fleets.

The following appointments have been made:—Surgeon Percy W. Bassett Smith, to the *Triton;* Mr. James J. H. Jackman, to be Surgeon and Agent at Dunmore. Fleet Surgeon George Mair, to the *Durham;* Fleet Surgeon Samuel Bamfield, to the *Sultan.* Staff Surgeon Rickard V. M'Carthy, to the *Serapis.* Surgeon Denis W. Donovan, to the *Monarch;* Surgeon Hugh D. Macnamara, to the *Helicon.*

RIFLE VOLUNTEERS.—4th Cheshire: Honorary Assistant-Surgeon William Bale, to be Acting Surgeon.—1st Forfar (Dundee): William Gibb, Gent, to be Acting Surgeon.—1st Isle of Wight: Acting Surgeon Evelyn Arthur Rich, to be Surgeon.—3rd London: Surgeon Charles Henry Bennett, M.D., is granted the honorary rank of Surgeon-Major.—7th Middlesex (London Scottish): Surgeon William Laidlaw Purves, M.D., resigns his commission.—1st Tower Hamlets (the Tower Hamlets Rifle Volunteer Brigade): William Dakin Waterhouse, Gent., to be Acting Surgeon.—1st Westmoreland: Robert Whinerey Leeming, Gent., to be Acting Surgeon.—2nd Oxfordshire: George Owen Willis, Gent., to be Acting Surgeon.

Correspondence.

"Audi alteram partem."

THE ROYAL COLLEGE OF SURGEONS.

To the Editor of THE LANCET.

SIR,—As the Council of the College of Surgeons have given the cold shoulder to their associates, whether Fellows or Members, it will be well to consider what further action should be taken by the latter to get their views introduced into the new Charter. I hope Mr. Swain will be heartily supported in his attempts to secure some of the many improvements that are required in the present constitution, both of the Council and the College, and that Mr. Hawkins and Mr. Pollock will both give their valuable aid in this direction. It is reasonable to conclude that whoever the authority may be (and I believe it is the Home Secretary) to whom application must be made before any alteration can be effected in the Charters, he would be willing to listen to the opinions of the large body of Fellows who are dissatisfied with the present order of things, as well as with some of the proposed changes. If the Council had manifested more consideration and less assurance, it would not have become imperative, as it now is, to fight the question to its end; and combined action on our part, directed with caution and judgment, cannot fail, I think, to be attended with good results.

I am, Sir, yours truly,

Norwich, May 27th, 1884. THOS. W. CROSSE, F.R.C.S.

To the Editor of THE LANCET.

SIR,—As the Council of the College are clearly at variance with a large proportion of their constituents, I think it most important that some combined action on the part of the Fellows should at once be taken to prevent alterations being made in the Charter which are distinctly retrograde and unconstitutional in their character. I trust that a meeting of the Fellows may be summoned in London for the purpose of taking further action before the election of councillors in July next.

I am, Sir, yours truly,

Liverpool, May 27th, 1884. REGINALD HARRISON.

"FEMALE MEDICAL EDUCATION IN BOMBAY."

To the Editor of THE LANCET.

SIR,—A paragraph, headed "Female Medical Education in Bombay," which appears in THE LANCET of April 5th, contains more than one erroneous statement. It says that Dr. Vandyke Carter's support of the female medical education scheme "aroused the indignation of his colleagues, who were inclined to view the scheme with disfavour, and would have liked to see it fall to the ground." The inference apparently meant to be drawn from this statement is that Dr. Carter's colleagues, whose "indignation" was thus aroused, were amongst his opponents at the recent Faculty meeting, when it was proposed to re-elect him as dean for the present year. Let me state at once that the "indignation" of Dr. Carter's colleagues is a pure myth, and was not in any way aroused in consequence of his support of the scheme in question. As far as I know, not one of them has offered the scheme the slightest opposition; and what is more, every one of the present professors and teachers of Grant College who took part in the election, myself amongst them, voted for Dr. Carter. For my own part, I beg to say that the female medical education scheme for this country has always commanded my warmest sympathy and support. What the scheme has aroused, however, is the indignation, or, to speak with greater exactness, the factious opposition of one or two of the leading general practitioners of this city, who, unfortunately, were able to carry with them a contingent of native members of the Medical Faculty of the university just sufficient to turn the scale against Dr. Carter. The editorial statement of a Bombay paper, alluded to in your paragraph, is totally untrue. The male students of Grant Medical College are not averse to "mixed classes"; at least, if they are, they have hitherto managed to conceal their aversion most successfully from those best qualified to know the existence of any such feeling. Nor have any of the professors been so much wanting in ordinary sense as to decline to deliver lectures to mixed classes. I do not believe, in fact, that the shadow of a thought even of doing so has entered the head of a single professor or teacher. With regard to the proposed municipal grant in aid of Miss Pechey's dispensary, I take this opportunity of mentioning that at a recent meeting of the Bombay Corporation the grant, notwithstanding Dr. Blanc's opposition, was sanctioned by a large majority, and its continuance guaranteed, besides, for three years.

I am, Sir, yours obediently,

W. GRAY, Surgeon-Major, I.M.D.,
Professor of Surgery, Grant Medical College.

Bombay, May 1st, 1884.

To the Editor of THE LANCET.

SIR,—Referring to the article on the above subject, which appeared in your issue of April 5th, allow me to state that you have been misinformed on many points. For example, it is not true that the students of Grant Medical College, an institution of which I have been a professor for the last eighteen years, are averse to mixed classes, nor is it true "that some of the professors (of Grant Medical College) are

about to decline to deliver lectures on that score." It is also not true that Dr. H. V. Carter's advocacy of the cause of female medical education, "aroused the indignation of his colleagues." Further, it is not true that the election of Surgeon-Major A. N. Hojel, L.K.Q.C.P.I., as dean of the Faculty of Medicine, in place of Dr. H. V. Carter, M.D. Lond., was the result of indignation aroused among Dr. Carter's colleagues, seeing that every one of these gentlemen who took part in the election voted for Dr. Carter, and not for his opponent. The Faculty of Medicine of the University of Bombay includes, in addition to Dr. Carter's colleagues in Grant Medical College, a very large number of members of the medical profession, many of whom are native graduates of the local university, engaged in general practice in Bombay. It was their vote which resulted in the election as Dean in Medicine of Surgeon-Major Hojel, on what a correspondent of an influential Indian newspaper, referring to the matter, justly calls the "astonishing platform" put forward by his proposer in nominating him for election—viz., that he (Surgeon-Major Hojel) was a gentleman who had at heart the interests of his colleagues, "men, not women." Any indignation therefore which was "aroused by Dr. Carter's advocacy of the cause of female medical education" was aroused, not among Dr. Carter's colleagues in Grant Medical College, but among the "general practitioners" of Bombay.—Yours faithfully,

J. B. LYON, F.C.S., F.I.C.,
Professor of Chemistry and Medical Jurisprudence,
Bombay, April 26th, 1884. Grant Medical College.

"REVACCINATION."

To the Editor of THE LANCET.

SIR,—I have been greatly interested in the discussion which your able article of the 26th ult. on this subject has evoked. Seeing as I do daily the disastrous effects of careless and inefficient vaccination and revaccination, I cannot forbear from adding my testimony to that of Dr. Gordon Black. Thus, on referring to my death-book, I find that in three out of the last twenty deaths the patients had submitted to revaccination within four years of the fatal attack of small-pox. True, the operation was in each case unsuccessful, but the patients had submitted to be cut for the cow-pock, and had, not unnaturally I think, considered themselves to be protected from a fatal attack of small-pox within so short a period as four years from the date of the so-called revaccination. Again, this day I admitted a case of confluent small-pox occurring in a child of seven years of age, and on questioning the father as to the vaccination, he informed me that the child had been once operated upon when a baby, but that the arm did not take, and that the medical man who had performed the operation informed him that it was a matter of no importance, and granted a certificate. In the same ward as this child is a young woman of twenty years of age suffering from confluent unmodified small-pox, who was operated on twice unsuccessfully as an infant, and then granted a certificate of insusceptibility.

Such cases as the preceding might be multiplied without end. I merely give them as examples of what is occurring in the wards of this hospital daily. It cannot in the present day, and in the fact of the overwhelming evidence which has been produced in your columns and elsewhere, be denied that revaccination when efficiently performed is an adequate safeguard against small-pox; to what, then, are we to attribute these too frequent failures? I believe we may class them under the following heads:—1. The repugnance of the public to have what they call a "bad arm"—that is to say, that they wish to have all the benefits of revaccination without any of its penalties. 2. Want of skill and carelessness on the part of the operator. 3. Inefficiency of the lymph supply. The latter cause of inefficiency can, I think, be only remedied by a more frequent resort to the bovine virus, and by this I do not mean lymph which has passed through an endless succession of calves, for lymph under such circumstances tends to deteriorate more rapidly than long humanised lymph, as Dr. Voigt, of Berlin, has so ably shown; but by looking out, as Jenner did, for sporadic cases of cow-pox wherever they may occur, and thus securing a means of revivifying our lymph supply, whether bovine or human.

I am, Sir, your obedient servant,
HERBERT GOUDE, F.R.C.S. Edin.,
Resident Surgeon, Small-pox and Vaccination Hospital,
May 26th, 1884. Highgate-hill, N.

"CREMATION *VERSUS* BURIAL."

To the Editor of THE LANCET.

SIR,—If the two gentlemen who addressed you last week will refer to Mr. Seymour Haden's writings on the subject of Cremation, the Vicar of Greenwich will see that the subject of soils has not escaped him, and Mr. Hastie that he was speaking not of the gross *volume*, but of the relative *rate* at which the gases from burned and buried bodies re-enter the atmosphere. It would be unfair to ask you to reprint any considerable portion of those writings, but it would save controversy, and a possible further misunderstanding of Mr. Haden's views, if you would reproduce the opening sentences of his letter to *The Times* of Jan. 12th, 1875, since those sentences not only state the case as between him and the cremationists, but present the reader with the foundation on which he rests the whole of his argument.

"'Interment,' the apostles of cremation tell us, is repulsive in idea, costly and ineffectual in fact, horrible in practice, a vilification of the dead, and a danger to the living. In a variety of publications which have excited much attention, they denounce not any particular mode of interment, or any palpable abuses which they recognise as having crept into the practice to discredit it, but the practice itself. They take no notice of the fact that the dead are little more than nominally buried, and that, by the interposition between them and the earth that should resolve them, of such media as wood, lead, brick, and the like, interment as a principle is rendered all but nugatory, and as a practice, deprived of its *raison d'être*. Finally, they leave it to be inferred, since they give us no hint to the contrary, that the evils thus created are inherent in the principle of interment, and upon this inference, and upon no other ground, found their recommendation of cremation. It is the object of this letter not so much to join issue with the cremationists, whose position I must venture to think untenable, as to invite attention to the important fact which underlies, and to some extent excuses, their proposals—viz., the fact that the dead are improperly buried; and, with reference to the serious and pressing evils which have resulted from our present mode of interment, to suggest a consideration of the following propositions:—1. That the natural destination of all organised bodies that have lived, and that die on the earth's surface, is the earth. 2. That the evils which they (the cremationists) would have us believe to be inseparable from the principle of interment are independent of that principle, and of our own creation. 3. That the source of these evils is to be found, not in the burial of the dead, but in the unreasoning sentiment which prompts us to keep them unburied as long as possible, and then to bury them in such a way that the earth can have no access to them. 4. That the burial of the body supposes its resolution by the direct agency of the earth to which we commit it, and that the earth is competent to effect that resolution, and to accomplish it innocuously. 5. That to seek to prevent the beneficent agency of the earth by enclosing the dead in hermetically sealed, imperishable coffins, brick graves, and vaults, is in the highest degree unphilosophical, since it engages us in a vain resistance to an inevitable dispensation, and has led us to accumulate in our midst a vast store of human remains in every stage and condition of decay. 6. That the remedy for such evils is not in cremation, but in a sensible recognition of, and a timely submission to, a well-defined law of nature, and, if necessary, in legislative action to enforce the provisions of that law." I am, Sir, your obedient servant,

May 27th, 1884. F.R.C.S.

MEDICAL LEGISLATION AND THE SCOTTISH UNIVERSITIES.

To the Editor of THE LANCET.

SIR,—I observe in your issue of the 17th inst. a letter from Prof. Struthers of Aberdeen University, in which, in his characteristic style, he maintains the superiority of his own school to the English schools, and gives it forth as a model for all others. Dr. Struthers must surely perceive that the medical legislation so much needed is not directed against the Universities of Scotland as teaching bodies, but as

examining boards. The following are a few facts connected with Prof. Struthers' own school, which will show, I think, that "reform" is not altogether out of place even there.

1. In 1863 a student attended midwifery and jurisprudence in Edinburgh, and came up for his final examination in Aberdeen, passing in all the subjects which he had studied in Aberdeen and being rejected in these two, for the former of which in Edinburgh he gained Sir J. Y. Simpson's first-class certificate and diploma and in jurisprudence the gold medal of the class.

2. In April, 1870, and in April, 1871, a candidate presented himself for his second and third degree examinations respectively. He was rejected in one subject on each occasion. The examiners in the former instance were a certain professor and an assessor examiner, and in the latter the same professor and the teacher of the subject with no assessor examiner. This fact caused inquiry to be made by the examining assessors, with the result of showing: first, that in the one instance of rejection, when the paper was compared by independent authorities with the paper of the candidate passing highest, it was found to be superior in merit; second, that in the other instance of rejection, when two professors were the examiners, a second oral examination was allowed two days later by the proper assessor, and the candidate made 90 per cent. His paper was valued at 80 per cent., but it was stated that his oral was so bad as to reduce the value of the paper to under 50 per cent, and yet, when examined according to statute, his oral raised the value of the paper to 90 per cent. The inference from this is that the professor indicated exercised an untoward influence on his colleague. These are facts which were made known at the time by the local papers and admitted by the university authorities.

3. At the graduation term of April, 1878, the graduates lodged with the Senatus the following protest:—"We have to complain of the manner in which the examinations in clinical surgery in your university were conducted by the examiners appointed by you, and in particular that the questions put to the different candidates differed in degree and were unsatisfactory as a test."

4. In 1883 and 1884 the students appealed to the University Court against a decision of the Senatus enforcing a new examination on them not provided for in the Ordinance of Privy Council. The appeal was sustained and the action of the Senatus declared *ultra vires* and incompetent. When these students graduated, certain of the medical professors refused to sign the diplomas, for the reason, as stated, that the students had not followed their "parental supervision." Whatever Dr. Struthers may say for himself, your readers will readily see the animus of the professors. I may say that steps were to have been taken anew to force the professors to carry out their statutory obligation in this matter; but the graduates believing that their diplomas would not be enhanced in value by these professors' names, the matter has been dropped.

Perhaps Dr. Struthers may look upon these facts as evidence of the "parental interest in individual students" the Aberdeen professors are so fond of showing, but I would submit that they are rather strong arguments why the duty of examining students should not be imposed on those who teach them, and as strong reasons why a Medical Reform Bill is urgently needed.

These facts fully justify the general feeling among successive graduates of the University of Aberdeen, that they would rather be examined by an independent Board than by their own teachers.—I am, Sir, yours truly,

Aberdeen, May 22nd, 1884. M.B. and C.M., April, 1884.

HEINRICH HEINE.

To the Editor of THE LANCET.

SIR,—The article in last Saturday's LANCET on Robert Burns possesses a singular suggestiveness. It cannot be read without recalling the name of another great lyric poet, who was pre-eminently an example of the neurotic temperament—Heinrich Heine. Heine's "mattress grave," on which he lay for the last ten years of life, the victim of spinal disease and ptosis, is familiar to the literary world; but it would be easy to show that the neurotic temperament conditioned his whole previous existence. M. Chenavard, the painter, who knew him well, said he could not recall the time when Heine was without some complaint or other. "Now it was his head, now his eyes, now his limbs, now his loins that were affected." He was refined in his tastes, and, though a German, never smoked—a proof perhaps of your dictum that the neurotic temperament is little tolerant of excess. See, again, the psychical characteristics of the two poets. The choicest productions of their exquisite Muse are short pieces not demanding any sustained effort. Heine's most beautiful poems, like Burns's, were founded on real incidents and inspired by the amatory passions common in a marked degree to the lives of both. How idle then to deplore, with Principal Shairp in his Life of the Scotch bard, Burns's libertinism, unless we are prepared to sacrifice at the same time the unique charm of his poetry, which had its source in the same psychical or physical (?) conditions.

I remain, Sir, yours faithfully,

Sussex-gardens, Hyde-park, May, 1884. T. FITZ-PATRICK.

NEWCASTLE-ON-TYNE.

(From our own Correspondent.)

THE TYNE TO SCANDINAVIA.

IN view of the approaching Congress of Medical Men in Copenhagen next August, a few remarks as to the advantages of proceeding to Scandinavian Europe by way of the Tyne may prove useful to some of your readers To Denmark the shortest route is from Newcastle to Esbjerb—I mean as regards the sea passage—which will occupy about thirty hours. From Esbjerb there is a pleasant railway journey to the opposite side of Jutland, by which a good deal of the quiet scenery of Denmark may be seen. Those who do not object to the sea voyage being a few hours more prolonged may proceed direct from Newcastle to Copenhagen, steamers, which are well advertised in the New castle papers, sailing frequently. Travellers wishing to see a little of Sweden and Norway while there is such a good opportunity may proceed direct from the Tyne to Gottenburg, from which point a steamer sails to Helsingborg and Elsinore, and thence to Copenhagen is not a long run by boat. Some very fine steamers, with passenger accommodation, sail nearly every other day for various points in Sweden along the coast. Anyone wishing to see a little of Sweden, and with whom time is a consideration, can proceed from the Tyne to Malmo, from which port Copenhagen is merely a ferry affair, as little steamers cross and recross nearly every half hour during the day. The Swedish steamers from the Tyne are first-class and well provided. A favourite holiday tour for medical men here is to Bergin, Norway, by the fine, fast, and first-class steamer *Norge*, sailing every Tuesday and returning on Saturday. It is possible by this steamer for one to see a good deal of the romantic beauties of Norway and return to Newcastle in a fortnight; and many of our *confrères* say that the view from Statheim down the marvellous Nævodal is alone worth the cost and trouble of the whole journey from Newcastle. The return ticket for the journey by the *Norge* is only £5, all meals (wine excepted) included. I would just remind the jaded practitioner that "there is life in the breeze of Norway, even if he only traverses a few of its almost countless fjords, or only skirts the bases of its mountains." I may say that there are very fine coasting steamers from Bergin to the quaint and picturesque Norwegian city of Drontheim, whence the rail may be taken to Christiania. From Christiania boats run every day to Copenhagen. A very nice holiday of a month, including some salmon-fishing and the Copenhagen Congress, may be had, and more than a glimpse of Denmark, Norway, and Sweden obtained, by a little pre-arrangement on the part of the traveller, who should, as regards the Norwegian portion, to prevent disappointment, write in good time to secure berths &c. to Mr. Jurgenson, Messrs. Borries, Craig, and Co., Newcastle-on-Tyne. Passengers by the *Norge* on arriving at Bergin will receive every assistance in regard to the best towns they can visit in the time at their disposal, on communicating with Mr. Halversen, the owner of the vessel, whose office is only a short distance from the wharf at which the steamer arrives. Over 1000 tourists entered Norway last season from Newcastle by way of Bergin. The want of a popular guide to Norway has been much felt; but this need, I am told, is likely to be soon supplied.

SUNDERLAND HOSPITAL MATTERS.

As a result of the public sympathy with the sufferers by the disaster to children in the Victoria Hall last year, about £5000 is available after satisfying all just claims on the fund and providing for the erection of a monumental group of sculpture. A Convalescent Home for Children appeared to be the most popular form for the memorial with the great body of the subscribers. There is some fear, however, that the funds may be, if not diverted from the proper object, at least allowed to take a subsidiary part in the memorial, so far as direct benefit to living children is concerned. A philanthropic lady of much and well deserved influence in the borough is endeavouring to add to the memorial a proposed training institution for domestic servants, where the training process with the convalescent scheme might be carried on under one roof. There may be good reasons in support of this hybrid institution, but it is much to be feared that they are mostly of an economical nature, and that it would not work satisfactorily in practice. Most things in the way of hospital provision are done in Sunderland in a roundabout manner. One would have thought that a small convalescent home in connexion with the present well established and useful Child's Hospital in Sunderland would have been the most direct and best way of utilising the fund. The discussion in the local papers as to the establishment of a town's hospital for infectious diseases still drags on in a dreary way; the disputants have each their pet schemes, and advocate them with great force, while the authorities do nothing.

Newcastle-on-Tyne, May 13th, 1884.

PARIS.

(From our Paris Correspondent.)

"L'HOMME A LA TETE DE CIRE."

GENERAL AMBERT has published in the *Souvenirs Militaires* an article under the above heading, a short account of which I send you in the hope that it will be found interesting. There is to be seen at Landrecies, in the Department of the North, an invalid artillery soldier, who was wounded in the late Franco-German War, when he was horribly mutilated by the bursting of a Prussian shell. The man's face was literally blown off, including both eyes, there being left behind some scanty remnants of the osseous and muscular systems. The skull, which is well covered with hair, was left intact, so that the man had a most hideous and ghastly appearance. This disfigurement has been completely concealed by a mask, which was made for him under the direction of the principal medical officer of Val de Grâce, in Paris, whither he had been transferred from the field ambulance. The mask was constructed by a surgeon-dentist named Delalain. It includes a false palate and a complete set of false teeth; and it is so perfect that the functions of respiration and mastication, which were necessarily imperfectly performed, are almost completely restored to their normal condition, and the voice, which was rather husky, has resumed its natural tone. The man speaks distinctly, the sense of smell, which had entirely disappeared, has returned, and he can even play the flute. He wears two false eyes, simply to fill up the cavities of the orbits, for the parts representing the eyelids in the mask are closed. In fact, the mask is so well adapted to what remains of the real face as to be considered one of the finest specimens of the prothetic art that could be devised. The man himself, whose name is Morean, and who is in perfect health, is looked upon as a living curiosity, and travellers go a good deal out of their way to see him. His face, or rather his mask, is of course without any expression, but his special senses, particularly that of touch, are extremely developed, and he goes by the sobriquet of "l'homme à la tête de cire." He wears the military Cross of Honour, and delights to talk about what he went through during the war. To add to his meagre pension he sells a small pamphlet containing a full description of his wounds, and of the apparatus that has been so skilfully devised as to render him at least presentable to his fellow creatures.

THE DESTRUCTION OF THE PHYLLOXERA.

The papers of the candidates for the prize of 300,000 francs offered by the Government for the most effectual means of destroying the phylloxera, which causes such devastation to the vine, not having satisfied the commission appointed to report on them, the prize was not awarded, and the instructions formerly given for the treatment of diseased vines were republished for the benefit of viticulturists. The treatment consists of submersion, and the application of the sulphuret of carbon and the sulpho-carbonate of potassium, which treatment has given great satisfaction, and nothing better has since been discovered.

In connexion with the subject of the treatment of diseased vines I may mention that M. de Chasseloup-Laubat proposes to substitute a substance, to which he has given the name of "œnophile," for the flowers of sulphur which has hitherto been employed as a remedy in the treatment of the oïdium which so frequently attacks grapes. The advantage claimed for this substance over sulphur is that the expense and labour attending the application of it are considerably less than those of sulphur, as one single application of œnophile is sufficient to remove the evil, provided it is applied during the dry season, for if done on a rainy day the chances of success are considerably lessened, as the substance would be washed off by the rain. Œnophile is a liquid substance, but, unfortunately, M. de Chasseloup-Laubat does not give its composition. It is applied by means of a spray-producer, and the solution dries in two or three hours, according to the temperature of the air. A great number of viticulturists have already made comparative experiments, and have found the great superiority of œnophile over sulphur. This opinion is corroborated by the Agricultural Society of the Department of the Dordogne, the most important wine-growing country in France, the Municipal Council of Périgueux, and the Society of Agriculturists of France, the latter having reported that œnophile is a remedy more certain and much less expensive than the sulphurage of the vines. Moreover, it has the advantage of not affecting the taste of the grapes, as is the case with sulphur.

M. PASTEUR.

The Minister of Public Instruction has obtained for M. Pasteur a large piece of ground situated in the Bois de Boulogne to carry out his interesting experiments with the virus of rabies, referred to in your annotation in THE LANCET last week. I may here mention that it is proposed to offer M. Pasteur a seat as life senator, in the room of M. Wurtz, recently deceased.

Owing to his delicate state of health, Professor Gosselin has resigned the professorship of Clinical Surgery at the Paris Faculty of Medicine. He was for many years surgeon to the Charité Hospital.

Paris, May 27th, 1884.

ROYAL COLLEGE OF PHYSICIANS.

A MEETING of the Comitia of the College of Physicians was held on Thursday, the 29th inst., Sir W. Jenner, Bart., K.C.B., President, in the chair. Replies to the addresses of condolence passed by the College were read from Her Majesty the Queen and H.R.H. the Duchess of Albany.

A proposal from Dr. Alexander Tweedie to present his portrait to the College was read, and was cordially accepted.

A memorandum from the Royal College of Surgeons relating to the manner in which it is proposed in the Medical Acts Amendment Bill to dispose of the surplus funds of the Medical Boards was referred to the Medical Bills Committee.

Mr. John Bland Sutton, the Manchester Scholar, was presented and congratulated on his success.

The election of Fellows was adjourned, the list of the nominees being referred to the Council for further consideration.

Dr. Dyce Duckworth was unanimously elected treasurer of the College in the room of the late Dr. Barclay.

A report was read from the Nomenclature Committee, which has completed its labours, and thanks were voted to the Committee.

The following addition to the Bye-laws was proposed for the first time, and carried:—"1. The President shall appoint annually, from among those Fellows of the College who have filled the office of Senior Censor, two Fellows as Vice-Presidents, who shall hold office for one year, and not be re-eligible until after the lapse of five years. 2. In case of the unavoidable absence of the President, or of his inability to act, one of the Vice-Presidents shall, for the pur-

pose of transacting routine business and on all matters of form, act as his Vicarius. 3. The Vice-Presidents on taking office shall give their faith to the Fellows, using the following words: 'I give my faith that I will discharge faithfully the duties entrusted to me as Vice-President.'"

MEDICAL NOTES IN PARLIAMENT.

IN the House of Lords on Monday, a Bill was brought in by Lord Stratheden and Campbell for the Prevention of Smoke in the Metropolis, and read a first time.

Small-pox and Revaccination.

In the House of Commons on Friday, Sir C. Dilke answered the series of questions by Dr. Cameron, notice of which was published in THE LANCET of last week. The following is the text of the answer of the President of the Local Government Board. We are aware of the large increase in the number of small-pox cases in the metropolis during the last eight weeks. The revaccination of persons exposed to infection is regarded by the medical adviser of the Board as constituting a most effective mode of preventing the spread of the disease. The question does not accurately set forth the duties of the medical officers of health and the public vaccinators. What is or should be done on the occurrence of small-pox is that the vaccination officer, with such assistance as the guardians may give him for the occasion, should make detailed visits to the houses in infected streets for the purpose of detecting any children who may not have been vaccinated, and of urging revaccination on adult and adolescents who have not already been revaccinated and who are exposed to danger of small-pox infection. The object of this special visiting is to urge people to apply without loss of time for vaccination and revaccination, and to apply at the place where it is provided in the best form and will be practised with the best success. Special places for revaccination in this form are frequently provided by guardians to meet the convenience of special classes of people. These measures have repeatedly been carried into effect through a union with excellent results, and the Board loses no opportunity of commending them to guardians. It may further be mentioned with regard to the metropolis, that in the case of persons who are removed to asylums of the managers—and these constitute a very large proportion of the cases of small-pox occurring in London—the patients are, as a rule, in the first instance attended by the district medical officer, and the Vaccination Acts contemplate that where a medical officer attends a person suffering from small-pox he may at once vaccinate or revaccinate any of the inmates of the house where such operation is required, and be paid for the vaccination or revaccination the same fee as the public vaccinator would have been entitled to receive. Under similar circumstances, the public vaccinator might revaccinate other than at the usual station, and the vaccination officer would doubtless, where necessary, give notice for the purpose. As the Board understand, revaccination at Glasgow under circumstances of hazard is then and there performed by the medical officer of health. As already stated, in exceptional cases the vaccination may be performed at once in England also, although it is not part of the general system on which English vaccination proceeds. The last part of the question raises the point whether, as indeed was advised by the Royal Commission on Hospitals, the vaccination arrangements should not be transferred from boards of guardians in the metropolis to the sanitary authorities. This is a question which at the present moment, when material changes are proposed in the constitution of the metropolitan sanitary authorities, cannot well be determined, but it is a matter which must receive full consideration as soon as such changes have been made.—Dr. Cameron immediately gave notice that at the earliest opportunity he would call attention to the whole subject; and subsequently the hon. member was fortunate enough in the ballot to secure the first place on July 1st for the purpose. It is understood that Mr. P. A. Taylor will take the opportunity to move an amendment antagonistic to compulsory vaccination.

MR. COLERIDGE KENNARD, M.P., has abandoned his Grocers' Licences Bill for the present session, but contemplates reintroducing it next session.

Obituary.

JOHN JONES PARRISH, M.R.C.S., L.S.A. LOND.

ON the 13th of May, in the family vault at Wordsley, were laid to rest the remains of John Jones Parrish, who had practised at Kingswinford for the space of thirty-five years; during that period his practice was large and extensive, and lay amongst the most notable families of the district. He was public vaccinator and medical officer of the No. 3 district of the Stourbridge Union, and surgeon to the D Company, 1st Regiment of the Staffordshire Rifles. He was known as a bold and skilful surgeon—his favourite operations being those of herniotomy and lithotomy—trained in a school of which Lawrence, Travers, Vincent, and Green were the exponents. He had little sympathy with aseptic surgery as taught by Lister and others, or the minutiæ of surgical detail as enjoined by the more modern school. It was a treat to hear him dilate upon the excellences of his old teachers and *confrères*, many of whom had long passed away, and he was never tired of praising his first favourite, Lawrence. He could also describe and give information about his fellow-student Palmer, who afterwards achieved notoriety as the winner of the Chester Cup and the poisoner of Cook with strychnia. A sportsman at heart, he was fond of his horse, his dog, and his gun, and could use the latter as deftly as his scalpel. A paralytic seizure some eighteen months ago left him less vigorous mentally and physically; but he carried on practice with some little assistance until the 8th inst., when an apoplectic seizure showed plainly that the end was nigh, and which took place on May 10th. He was somewhat eccentric in manner, but under a bluff exterior he carried a generous and warm heart, and will be greatly regretted by his numerous friends and patients.

WILLIAM JOB COLLINS, M.D.

DR. WILLIAM JOB COLLINS, who died on May 10th, at his residence, Albert-terrace, Regent's-park, was born at Oxford in 1818, and educated at New College. An accident sustained in the hunting-field when quite a lad diverted his attention from the Church, for which he was originally intended, to the pursuit of medical studies, and in 1837 he was apprenticed to Mr. Ward of Oxford. It was not, however, long before he quitted his native city and betook himself to London, and in 1840 continued his apprenticeship under the late Mr. Fowke of Berkeley-square. In 1844 he entered University College, became M.R.C.S. in 1846, L.M. in 1853, M.D. of Aberdeen in 1854, and L.R.C.P. in 1859. For thirty years he carried on a very extensive practice in the vicinity of Regent's-park, but his energy and talent were active in other spheres than that of physic. A keen and vigorous sportsman, his cheery presence was a constant feature with Her Majesty's staghounds, while as an amateur artist he exhibited "on the line" at Burlington House. Dr. Collins married in 1852 the eldest daughter of E. Treacher, Esq., of Huguenot descent, by whom he had four children, who survive him.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen passed the first part of the Professional Examination for the Fellowship at meetings of the Board of Examiners on the 24th, 26th, 27th, and 28th inst.:—

Thomas Sinclair, Belfast; William G. Richardson, Newcastle-on-Tyne; Herbert Herbert, Leeds; R. F. C. Leith, Edinburgh; P. M. O'Brien, Liverpool; Walter H. Jessop, Cambridge and St. Bartholomew's Hospital; P. B. Conolly, Charing-cross Hospital; E. T. Thring, University College; Arthur Hardwicke, Westminster Hospital; Reginald F. Jowers, St. Bartholomew's Hospital; Henry Hyde, King's College; Henry C. Bowman, Owens College; Herbert Lund, Cambridge and Guy's Hospital; William W. C. Robson and Robert Nairn, St. Thomas's Hospital; Frederick C. Bury and Arthur H. Smith, Owens College; John R. Bradford, University College; John Richards, Manchester and Edinburgh; Lionel J. Pisani, Charing-cross Hospital; Edward F. White, St. Thomas's Hospital and King's College; James W. Barrett, Melbourne and King's College; G. L. Galpin, Middlesex and St. Mary's Hospitals; Herbert H. Brown and Thomas W. P. Lawrence, University College; W. G. Spencer and Edmund F. Trevelyan, St. Bartholomew's Hospital; Edward S. Goodby, St. Thomas's Hospital and Newcastle-on-Tyne; Charles F. Seville, Manchester; Sidney Wacher and Chas. Metzgar, Guy's Hospital; J. Thomas, Leeds and London Hospital; Russell Coombe, Cambridge and St. George's Hospital.

For the final Fellowship examination which commenced on the 29th inst. there are 29 candidates.

The following gentlemen passed the Primary Examination in Anatomy and Physiology at meetings of the Board of Examiners on the 22nd and 23rd inst.:—

Edward B. Ormerod, Charles P. White, Arthur R. Down, William J. Rogers, Percy G. Gilmore, and George A. Edsell, St. Bartholomew's Hospital; Hugh Exton, Walter H. Moyle, and Thos. C. Simmonds, London Hospital; Arthur Crossley, Peter Paget, Arthur E. Palmer, and Arthur T. Brown, Guy's Hospital; George H. Seagrave, Albert C. Lewis, and Arthur E. Paul, University College; Herbert P. Prankerd, Edinburgh and Westminster Hospital; Walter L. Wyatt, Middlesex Hospital; William G. Bower and William B. Wedgwood, King's College; Wm. J. Olivey and Samuel G. Moores, St. Thomas's Hospital; William T. Rayne, Westminster Hospital.

Of the 148 candidates examined during last week, 69 failed to satisfy the Board, and were referred for three, and 7 candidates for six, months' further anatomical and physiological study. — The Primary Examination, which commenced on the 1st of April, was brought to a close on the 23rd inst. The total number of candidates examined was 581, of whom 402 were successful, and 163 were referred for three and 16 for six months. During the corresponding period of last year 588 candidates were examined, of whom 441 were successful and 147 failed.

ROYAL COLLEGE OF SURGEONS IN IRELAND. — At a meeting of the Court of Examiners on the 8th inst. and following days the undermentioned candidates were admitted Licentiates of the College:—

J. Acheson Berkeley, George A. Bagot, Louis A. F. Bate, John Bernal, Francis L. Carte, James V. Collins, Cecil Cronin, T. Crow, Alexander Cuffe, Thomas J. Daly, Julius Barry Delaney, Thomas L. Dillon, Cuthbert Eccles, Patrick J. Ford, Frederick J. Greig, James Hanna, Denis Kennedy, Graham Kennedy, Charles R. Kilkelly, Benjamin Lane, Frederick D. Lawson, John Lowney, Edward McNutly, Thomas J. McGrath, James H. Maguire, E. L. Minchin, Cornelius R. Moloney, Walter A. Murray, Llewellyn J. M. Nash, Charles J. Perrott, William W. Scott, Edward N. Smartt, Alexander Stewart, Malcolm E. Thomson, Augustus M. Westropp, H. E. P. Wright, Thomas N. Wright, John H. Woods, John F. Yates.

APOTHECARIES' HALL. — The following gentlemen passed the examination in the Science and Practice of Medicine, and received certificates to practise, on May 22nd:—

East, C. Harry, The Limes, Kettering, Northamptonshire.
Lavers, Thomas George Jeffs, Clarendon-road.
Roberts, Leonard, Bishops Lydeard.
Tomlins, Wm. Henry, Rutland-street, Hampstead-road.
Wilding, James, Lambourne-road, Clapham.

The following gentleman also on the same day passed the Primary Professional Examination:—

Shaw, Arthur, University College Hospital.

THE Hospital Saturday collection at Birmingham last week amounted to £6004, as compared with £5232 on the corresponding date last year.

IT has been decided to erect a small-pox hospital on the Gore Farm Estate, Essex, at a cost, it is stated, of £120,000.

THE General Medical Council has recently passed a resolution including the Responsions Examination at St. David's College, Lampeter, in the list of preliminary examinations recognised by the Council.

THE ROYAL RED CROSS.—The Queen has been graciously pleased to confer the decoration of the "Royal Red Cross" upon the undermentioned ladies, under the provisions of Her Majesty's warrant dated 23rd April, 1883—viz.: Mrs. Margaret Maistre, Mrs. Anne Fox, Mrs. M. J. W. Armfield, and Mrs. Gildea.

ALLEGED POISONING BY TINNED SALMON.—At the inquest at Wolverhampton on Monday on two persons whose deaths occurred shortly after partaking of tinned salmon, the medical witnesses gave it as their opinion that the poison which proved fatal was not of a metallic, but possibly of an animal or a vegetable nature. The inquiry was adjourned.

THE HOSPITAL SATURDAY FUND.—A conference of working men was held at the room of the Society of Arts on the 24th inst., to consider the best means of promoting the success of the Hospital Saturday movement in London. Resolutions declaring it desirable that the districts should be subdivided, so as not to exceed an area of two miles square, and that the issue of collection sheets and boxes should be restricted as far as possible to the central office, were carried without discussion. A resolution to the effect that it is desirable that, by contributing to the medical charities of London, the working class should secure for themselves an an adequate representation upon the governing bodies of the various institutions was carried, as was also one urging upon the attention of the central board of the Hospital Saturday Fund the desirability of securing by the insertion of some clause in the code of bye-laws the right to all firms subscribing through a committee to elect representatives on the board, and that all local committees have the representation as provided for in the constitution with the addition that committees paying over £100 to the central fund shall have an additional representative for each additional £100.

NEW HOSPITAL FOR BURNLEY.—The foundation stone of a new hospital in this town was laid on the 24th inst. The building is intended to afford accommodation for forty-four beds, and the outlay is estimated at £12,000. Already £9000 has been received, including £3000 raised by workpeople by means of mill collections, in addition to which £3000 has been promised. In honour of the Queen's birthday the hospital was named the Victoria Hospital.

THE SUNDERLAND INFECTIOUS DISEASES HOSPITAL.—For the sum of £5000, or £416 per acre, a site, which appears a highly eligible one, has been secured by the Health Committee of the Sunderland Corporation for the proposed Infectious Diseases Hospital. The plot of land of twelve acres possesses good natural facilities for drainage, and is situated about a mile to the west of the borough.

NEW GROCERS' COMPANY RESEARCH SCHOLARSHIPS.—At a Court of Assistants of the Worshipful Company of Grocers held on May 21st, the following candidates were elected to the Company Scholarships for research into the causes of important diseases:—1. W. North (renewal): Etiology of Ague. 2. L. C. Wooldridge, D.Sc., M.B.: Hæmorrhagic Disease, Pernicious Anæmia, and Blood-clotting. 3. A. Lingard, M.R.C.S.: Intimate Etiology of Enteric Fever.

WESTMINSTER HOSPITAL.—At a meeting of the House Committee of the Westminster Hospital held on May 27th, a building committee was appointed for the purpose of making arrangements for the erection of a medical school on the site already purchased in Caxton-street, to the west of the Westminster Town Hall. In a circular just issued the committee acknowledge the receipt of contributions to the amount of £4588 in response to their appeal for £15,000 to enable them to carry out the improvements begun seven years ago.

COLLEGE PRIZES.—The Council of the Royal College of Surgeons has just announced the following as the subject for the Collegial Triennial Prize: "The Nature of Inhibitory Action in the Animal Body to be elucidated by Original Research." This prize consists of the John Hunter Medal, executed in gold to the value of fifty guineas, or, at the option of the successful author of the dissertation, of the said medal executed in bronze with an honorarium of fifty pounds. Essays for this prize must be sent in on or before Thursday, December 31st, 1885. The following are the subjects for the Jacksonian Prize of this and the succeeding year: "The Surgical Treatment of Uterine Tumours, both Innocent and Malignant," and "The Diagnosis and Treatment of such Affections of the Kidney as are amenable to Direct Surgical Interference." The value of these latter prizes is the amount of the dividend (between £12 and £13) received from the Trust.

Medical Appointments.

Intimations for this column must be sent DIRECT *to the Office of* THE LANCET *before 9 o'clock on Thursday Morning at the latest.*

CAIGER, F. F., M.B., M.S., M.R.C.S., L.R.C.P., has been appointed House-Surgeon to St. Thomas's Hospital.

CALDERWOOD, GEORGE, M.D., C.M.Glas., has been appointed Medical Officer for the Egremont District of the Whitehaven Union.

COOPER, G. F., M.R.C.S., L.R.C.P., has been appointed House-Surgeon to St. Thomas's Hospital.

GLASSINGTON, C. W., M.R.C.S., L.D.S.Ed., has been appointed an Anæsthetist to the National Dental Hospital.

GRANT, HENRY L., M.B., Assistant Medical Officer at Garlands Asylum, has been appointed Assistant Medical Officer to the Buckingham County Asylum, Stone, near Aylesbury.

GREEN, C. D., M.R.C.S., L.R.C.P., has been appointed Resident House-Physician to St. Thomas's Hospital.

HEBBERT, C. A., M.R.C.P.Lond., has been appointed Demonstrator of Anatomy in the Westminster Hospital Medical School.

HEWITT, F. W., B.A., M.B., M.R.C.S., has been appointed an Anæsthetist to the National Dental Hospital.

HULL, WALTER, M.B., M.R.C.S., L.R.C.P., has been appointed Resident House-Physician to St. Thomas's Hospital.

JESSOP, C. M., M.R.C.P., has been appointed Physician to the St. Pancras and Northern Dispensary.

JOHNSTON, G. D., M.R.C.S., L.R.C.P., has been appointed House-Surgeon to St. Thomas's Hospital.

JONES, ARTHUR C. BRETT, M.R.C.S., has been appointed Medical Officer for the Ampingham District of the Oakham Union.

KING, THOMAS RADFORD, M.D.Ed., has been appointed Resident Medical Superintendent of the Hokitika Hospital, New Zealand.

LEVINGE, EDW. GEORGE, M.B.Dub., L.R.C.S.I., has been appointed Resident Medical Superintendent to Mount View Lunatic Asylum, Wellington, New Zealand.

LYON, T. GLOVER, M.R.C.S., L.R.C.P., has been appointed Clinical Assistant in the Skin Department, St. Thomas's Hospital.

NEALE, A. J., M.B., has been appointed Medical Officer to the Manchester Hospital for Diseases of the Skin, vice H. Stanley Gall, M.B., deceased.

ORFORD, JOHN, M.R.C.S., L.R.C.P., has been appointed Resident Accoucheur to St. Thomas's Hospital.

PATTERSON, W. T., L.D.S.E., has been appointed House-Surgeon to the National Dental Hospital.

PHILLIPS, F. LESLIE, M.D.Brux., has been appointed Medical Officer of Health to the Balsall Heath Local Board.

ROBINSON, H. B., M.R.C.S., L.R.C.P., has been appointed Assistant House-Surgeon to St. Thomas's Hospital.

SANEYOSHI, Y., M.R.C.S., L.R.C.P., has been appointed Assistant House-Physician to St. Thomas's Hospital.

SCUTT, T., M.R.C.S., L.R.C.P., has been appointed Assistant House-Physician to St. Thomas's Hospital.

SMITH, FREDERICK WALTER, L.R.C.P.Lond., M.R.C.S., L.S.A.Lond., has been appointed Medical Officer to St. George's Workhouse, St. Saviour's Union.

STEVENS, FRANCIS JOSEPH, M.R.C.S., L.S.A.Lond., has been appointed Medical Officer for the Kilburn District of the Thirsk Union.

STONE, F. W. S., M.R.C.S., L.R.C.P., has been appointed Non-resident House-Physician to St. Thomas's Hospital.

SUTTON, S. W., M.D., B.S., &c., has been appointed Ophthalmic Assistant to St. Thomas's Hospital.

TOMKINS, HENRY, M.D.Q.U.I., M.R.C.S., has been reappointed Resident Medical Officer to the Monsall Fever Hospital, Manchester.

TYRRELL, WALTER, L.R.C.P., M.R.C.S., has been appointed an Anæsthetist to the National Dental Hospital.

Births, Marriages, and Deaths.

BIRTHS.

BENNETT.—On the 20th ult., at Rawal Pindi, Punjab, the wife of Surgeon-Major John Bennett, Civil Surgeon, prematurely, of twin daughters.

BOOKLESS.—On the 21st inst., at 26, Wimbledon-hill-road, the wife of J. Pitcairn Bookless, Esq., M.D., of a daughter.

FLEMING.—On the 27th inst., at 155, Bath-street, Glasgow, the wife of William James Fleming, M.D., of a son.

GREENFIELD.—On the 24th inst., at Heriot-row, Edinburgh, the wife of William Smith Greenfield, M.D., F.R.C.P., of a son.

ROBERTSON.—On the 25th inst., at Gonville House, Roehampton-park, S.W., the wife of A. Milne Robertson, M.D., of a son.

WILKIN.—On the 21st inst., at The Warren, Beckenham-park, Kent, the wife of J. F. Wilkin, M.D., of a son.

MARRIAGES.

BAKER—MOORE.—On the 29th March, at Akyab, British Burma, Oswald Baker, Civil Surgeon, to Katharine Mary Moore, daughter of J. L. Moore, of Hoxne, Suffolk.

BOWMAN—THOMSON.—On the 21st inst., at St. Stephen's, Hammersmith, Richard Bowman, L.R.C.P., to Florence Julia Alice, widow of the late James Cameron Thomson, of Penang.

CAMPBELL—MOSS.—On the 22nd inst., at the Superintendent Registrar's Office, Marlces-road, Kensington, by licence, William Frederick Campbell, L.R.C.P.Ed. &c., only surviving son of the late Major Patrick Scott Campbell, R.A., to Julia, youngest child of the late Saul Moss, formerly of Kingston, Jamaica.

COOPER—ASHBURNER.—On the 7th inst., at All Saints' Church, Bombay, Richard Gilpin Cooper, M.D., Surgeon, Bombay Army, to Jessie Yuill Pelly, third daughter of Major-General G. E. Ashburner, Bombay Army (Retired List), and of St. John's-park, Blackheath.

DEATHS.

ALDRED.—On the 21st inst., in Hyde-park, suddenly, H. Allen Aldred, M.D., of Westbourne-park.

ALDRIDGE.—On the 22nd inst., at Shirley House, Dorchester, John Petty Aldridge, M.D. & J.P., aged 71.

DAVID.—On the 18th inst., at Sydenham-villas, Cheltenham, John David, M.D., son of the late Edward David, of Swansea, Glamorganshire, aged 67.

FINCH.—On the 28th inst., at Pau, Basses Pyrénées, France, Frederick Cotton Finch, M.D., late of Blackheath, Kent, aged 70.

JONES.—On the 16th inst., at his residence, St. Andrew's-terrace, Plymouth, Charles Marchant Jones, L.R.C.P., F.R.C.S. (late of Amoy), aged 49.

MURIEL.—On the 26th inst., at the Palace-green, Ely, John Muriel, J.P., D.L., F.R.C.S., in his 85th year.

N.B.—A fee of 5s. is charged for the Insertion of Notices of Births, Marriages, and Deaths.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Stewards' Instruments.)

THE LANCET OFFICE, May 29th, 1884.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind	Dry Bulb	Wet Bulb	Solar Radia in Vacuo.	Max. Temp. Shade.	Min. Temp.	Rain fall.	Remarks at 8.30 A.M.
May 23	30·27	E.	63	57	116	78	50	..	Bright
,, 24	30·05	E.	64	57	117	80	52	..	Hazy
,, 25	30·03	S.E.	55	50	69	58	48	..	Overcast
,, 26	30·19	E.	56	52	109	69	48	·02	Bright
,, 27	30·34	E.	54	50	104	70	45	..	Bright
,, 28	30·23	E.	49	45	..	56	44	..	Overcast
,, 29	30·17	E.	51	47	..	53	47	..	Overcast

Medical Diary for the ensuing Week.

Monday, June 2.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.

METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.

ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.

ST. MARK'S HOSPITAL.—Operations, 2 P.M.; on Tuesday, 9 A.M.

HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.

ROYAL INSTITUTION.—5 P.M. General Monthly Meeting.

Tuesday, June 3.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour. Ophthalmic Operations on Mondays at 1.30 P.M., and Thursdays at 2 P.M.

WESTMINSTER HOSPITAL.—Operations, 2 P.M.

WEST LONDON HOSPITAL.—Operations, 2.30 P.M.

ROYAL INSTITUTION.—3 P.M. Professor Gamgee: Nerve and Muscle.

Wednesday, June 4.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.—Ophthalmic Operations on Tuesdays and Thursdays, at 1.30 P.M.

ST. MARY'S HOSPITAL.—Operations, 1½ P.M.—Skin Department: 9.30 A.M., on Tuesdays and Fridays.

ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.

LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.

GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.

SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.

UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.—Skin Department: 1.45 P.M., and on Saturday at 9.15 A.M.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Mr. Edward Albert Schäfer: The Functions of the Marginal Convolution.

OBSTETRICAL SOCIETY OF LONDON.—8 P.M. Specimens will be shown by Dr. Godson, Dr. Galabin, Dr. Aveling, Dr. Walters, Dr. Malins, Dr. John Williams, and Dr. R. Barnes.—Dr. Playfair: Note on the Absorption, with ultimate recovery, of Thrombosis of the Pulmonary Artery in the Puerperal State.—Dr. Matthews Duncan: On Fœtal Revolutions.—Dr. Lediard: Fibro-cystic Myoma of Uterus.

Thursday, June 5.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.

ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.

CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

NORTH-WEST LONDON HOSPITAL.—Operations, 2½ P.M.

ROYAL INSTITUTION.—3 P.M. Professor Dewar: On Flame, &c.

OPHTHALMOLOGICAL SOCIETY OF THE UNITED KINGDOM.—8 P.M. Dr. P. H. Mules: Drawing of Fundus with Choroidal Tubercles; Stained Sections of Tuberculous Choroid.—Dr. Bailey: (1) Paralysis of External Rectus and Mydriasis, with a recent history of Uniocular Diplopia. (2) Sympathetic Papillitis.—Messrs. Critchett and Juler: Case of Choroiditis Disseminata.—Messrs. Cowell and Juler: Mounted Specimens of Intra-ocular Sarcoma.—Dr. Sharkey and Mr. J. B. Lawford: Optic Neuritis associated with Acute Myelitis.—Mr. Nettleship: (1) Cases of Recovery from Amaurosis in Infants. (2) Cases of Retro-ocular Neuritis.—Dr. C. E. Fitzgerald: An Instrument for showing the Action of the Accommodation.—Mr. J. B. Lawford: Amblyopia with Contraction of Visual Fields and Central Scotoma, ending in recovery.—Mr. Adams Frost: Ciliary Staphyloma following Irido-choroiditis, sympathetic ophthalmitis subsequent to excision.—Mr. Simeon Snell.—Case of Uniocular Diplopia.

Friday, June 6.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.

ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.

KING'S COLLEGE HOSPITAL.—Operations, 2 P.M.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Mr. Edward Albert Schäfer: The Analysis of Voluntary Muscular Action.

ROYAL INSTITUTION.—3 P.M. Mr. Willoughby Smith: Electric Induction Experiments.

Saturday, June 7.

KING'S COLLEGE HOSPITAL.—Operations, 1 P.M.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

ROYAL INSTITUTION.—3 P.M. Professor Bonney: Microscopical Geology.

Notes, Short Comments, and Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editor."

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for publication or private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe, or recommend practitioners.

Local papers containing reports or news-paragraphs should be marked.

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "To the Publisher."*

COST OF DIPLOMAS UNDER THE NEW BILL.

Nottingham.—We do not anticipate the result mentioned by our correspondent. The consolidation of Examining Boards *ought* rather to tend to make diplomas cheaper. But the point is of importance, and we will see that it shall not be lost sight of. It must be remembered, too, that one other great advantage to students is contemplated in this Bill—the abolition of all *half qualifications;* so that when the student has passed the Licensing Board he has done so once for all, and has not to get qualified in surgery here and in medicine elsewhere.

"MEDICAL ETIQUETTE."

To the Editor of THE LANCET.

SIR,—I willingly accept Dr. Wight's explanation, and his version of the facts where they differ from mine. It is quite clear that both Dr. Wight's assistant and myself were misled by the midwife's statements and suppression of facts. I found the placenta adherent, and removed it (the midwife made no mention of this to Dr. Wight's assistant), and I also saw the broken umbilical cord. One part of Dr. Wight's letter I cannot understand. According to my calculations, Dr. Wight's assistant must have arrived within ten minutes of my leaving the case, though he was sent for long before I was. The patient when I left was as comfortably placed in bed as circumstances would allow; the uterus was firmly contracted, the binder adjusted, and there was no hæmorrhage. I can understand that if the binder had been removed the uterus might have relaxed again. But why was the binder removed? The mixture I sent contained ergot (and I had previously given her ergot); and I omitted to say in my last letter that one of the messages I received was that the doctor (Dr. Wight's assistant) said, "If the patient had taken that medicine it would have killed her." Of course, I do not now for a moment believe that Dr. Wight's assistant ever said any such thing. I may mention that since the publication of my letter Dr. Wight's assistant called on me, and gave me an explanation somewhat similar to Dr. Wight's in your last issue. Dr. Wight's assistant himself told me that he asked for a fee, and that the answer he received was, "Dr. Wight never charges me anything." I have not seen the case since; so, between the three of us, I rather wonder what has become of the patient. After Dr. Wight's explanation I hope I may be allowed to withdraw anything in my letter that may appear offensive to him or his assistant; but at the same time I shall be obliged if you will advise me with regard to the third and fourth questions in my letter to you of May 3rd last.—I remain, Sir, yours truly,

EUSTACE J. DE GRUYTHER, L.R.C.P., L.R.C.S. Edin.

Jackson-road, Holloway, N., May 27th, 1884.

*** After Dr. Wight's statement of the facts of this case, as far as regards him and his assistant, we think the case might be allowed to rest. Fine points of etiquette are a little misplaced in cases of impending sinking from post-partum hæmorrhage. Consideration for the life of the woman overrides all other considerations. But Mr. De Gruyther specifically requests our opinion on two points of his letter—not of the 3rd by the way, but the 10th. We answer that any claim he has would lie against the husband of the patient, and not against the midwife. A midwife of eighty—or any other age for that matter—might fairly say that to wash out the uterus was not part of her duty, and this was the duty which seemed to lead her to ask to be allowed to hand over the case to Mr. De Gruyther. Under the circumstances it would not be wise to summon the midwife to the County Court. It would have been quite right for the assistant to ask for a fee. He was not bound to know the generous terms on which his principal had always given his help to the midwife of eighty.—ED. L.

EXAMINATIONS AT THE ROYAL COLLEGE OF SURGEONS.

AT the Primary, or Anatomical and Physiological, Examinations for the Fellowship of the College, on Friday last, the 23rd inst., the following questions in Anatomy were submitted, when the candidates were required to answer at least three out of the four questions between 1 and 4 P.M.:—

1. Give the dissection required to expose the complete dome of the pleura of the right side.
2. Describe the action of the muscles passing between the trunk and upper limb in reference to the movements of the shoulder-girdle and arm upon the trunk.
3. Describe fully the twelfth dorsal vertebra, mentioning the various structures attached to it.
4. Describe the dissection required to expose the transversus pedis muscle.

The following were the questions in Physiology, for which from 9 A.M. to 12 noon was allowed for answering three out of the four questions:—

1. What are the distinctive functional and structural characters of animal and vegetable cells? Give the evidence on which your statements rest.
2. Describe the means by which a muscle-curve is obtained. What circumstances modify the contraction of muscle, and the form of the muscle-curve?
3. Assuming the right forearm to have been voluntarily flexed, describe the course of the nerve-impulse by which this movement was excited, from the cerebral motor ganglion-cells to its exit from the cord. Give the evidence on which your answer is based.
4. Describe the mechanisms by which accommodation is accomplished, and the methods of accurately determining them.

The names of the successful candidates are published on another page.

IODOFORM SPRAY.

To the Editor of THE LANCET.

SIR,—In reply to Dr. Davies' question, I have much pleasure in submitting the partial results of some experiments I am now making. Iodoform can be dissolved in the ethers and essential oils. A saturated solution in alcohol contains 4 per cent., in oil of lavender 7 per cent., in ether 16 per cent., of iodoform (see Vulpius in the *Archiv der Pharm.*, Jan. 1882). I believe chloroform dissolves somewhat less than ether, and its solution has the colour of tincture of cinnamon, B.P., though free iodine does not seem to be present. An ethereal solution is deep orange colour. At present I prepare a spray as follows:—Take of the ethereal solution, one drachm; of the choloroform solution, one scruple; of fresh tincture of senega, a drachm and a half; water to two ounces. The result is a straw-coloured mixture holding in suspension iodoform in a state of very fine subdivision. The addition of a little ol. pini sylvestris (before adding the water) will do much to disguise the odour of the iodoform, and probably supply a therapeutic adjunct of some value in throat, lung, and Eustachian cases.

While I was assistant house-surgeon to the Rotherham Hospital and Dispensary, I tried iodoform (in half grain pills) pretty freely among our out-patients in cases of phthisis, and was not altogether displeased with some of the results obtained. In renewing the treatment I should incline to prescribe the drug in smaller doses, and in a finer state of division.

I am, Sir, yours truly,

Charlwood-street, S.W., May 26th, 1884. ALFRED LEACH.

PADDINGTON-GREEN CHILDREN'S HOSPITAL.

IN THE LANCET of May 24th it was stated "that the number of out-patients attended at this institution during the past year was 18,659." We are informed that this figure represents the total attendance of out-patients, and that the number of new cases was 6500.

Mr. T. W. Carmalt Jones.—No.

THE LATE DEAN OF BANGOR.

To the Editor of THE LANCET.

SIR,—I have read with great pain in the *Western Mail* of yesterday some references to myself and my advice to the much lamented Dean of Bangor. I cannot, however, even in defence of my reputation for skill in nervous maladies, break faith with those who have once consulted me. It is quite sufficient for my purpose to state that I recommended several courses, all of which I have found most successful in treating similar cases, and the one course that I most strongly opposed was his returning into Wales, receiving and answering letters, reading newspapers, and being hourly reminded of his beloved work. During the years that I have made nervous troubles my special study, it has always been my opinion, which I see no reason to alter, that they cannot be successfully treated amid surroundings like those in which they originate. The day before the Dean of Bangor left Ben Rhydding he declared himself to be better than he had been for months, and his many friends here were greatly pleased with his improved appearance and spirits.

I am, Sir, yours faithfully,

Ben Rhydding, May 28th, 1884. JOHN FLETCHER LITTLE.

Hope.—1. Yes.—2. Yes, if the habit has not been practised to a ruinous extent.

Mr. Henry Lore may obtain full information from the Secretary of the Society, 53, Berners-street, W.

"SURELY THIS IS NOT INSANITY."

DR. STRAHAN must really excuse us from discussing seriously the hypothetical case of the man who, suffering from "temper disease," daily threatens the cook. What we meant, and what we again assert, is simply that there is a tendency to multiply forms and varieties of mental disease, and to characterise as "insanity" that which is not deserving of that designation. To this opinion we adhere; but as nothing would be gained by pursuing the present controversy further, we must ask leave to close it here. Our concluding remark shall be, that it is not for the advantage of the public or the profession that the eccentricities and weaknesses of human nature should *all* be included under the undefined, and therefore meaningless, term "insanity"; and we trust it may not be long before a reaction of common sense begins to make itself evident.

Historicus (Paris).—That the *lues venerea* was known in Europe before 1496 has been confidently asserted by sundry physicians. On this subject reference may be made to the work, in quarto, entitled "De Morbo Fœdo et Occulto," by Dr. Peter Pintor of Valentia, who died, aged eighty-three, in Rome, in the year 1503, when physician to the Spanish Pope, Alexander the Sixth.

Puzzled.—The orders of the Local Government Board are imperative in requiring the duties of a medical officer to be performed personally, though he may be assisted by a deputy approved by the guardians. He cannot, therefore, delegate his duties to even a qualified substitute.

A CORRECTION.

To the Editor of THE LANCET.

SIR,—May I ask you kindly to insert the following correction in your next issue. In the report of the discussion upon Dr. Percy Kidd's cases of aneurism of the pulmonary artery I am reported to have said that there was a large number of cases of aneurism in which there had been no hæmoptysis. This, I think, is open to misconstruction, as being a statement which is in all probability true, though not yet established. In a communication upon the subject to the Pathological Society a few meetings ago I stated that, so far as I knew, all the cases of aneurism of the pulmonary artery hitherto described came from the bodies of patients who had died from profuse hæmoptysis, and that it was remarkable that up to the present no one had been exhibited in the lungs of phthisical patients who had died in other ways. I ventured to predict that their frequent discovery would probably reward a more careful search. The special interest of Dr. Kidd's cases is that, I believe, they are the first of their kind, and that one of them, that in which twenty-two aneurisms were discovered in the one lung, will probably continue unique for a long time to come.—I am, Sir, yours very truly,

Wimpole-street, W., May 24th, 1884. SAMUEL WEST.

Stand Sure.—Something depends on the circumstances, and whether the post was advertised as vacant. But the circular is rather "shoppy" in style.

Dubious.—The most satisfactory way to obtain the information desired would probably be to write to the registrar of the university, as no authoritative list is, so far as we are aware, published.

M.D. BRUSSELS.

To the Editor of THE LANCET.

SIR,—There is such a vague and somewhat erroneous impression in England about the above degree that I trust you will be able to insert this in THE LANCET; it will save a number of medical men a vast amount of disappointment, &c. I found the examinations most exacting and minute, especially in pathology, medicine, dissections, hygiene, and clinical surgery, quite equal to the best London examinations. Out of sixteen men up this month only six passed, equivalent to a percentage of over sixty-six rejected. True, some men succeed who are known to be not well up generally. This happens in all examinations, because they are fortunate in getting what they do know; but I strongly advise no one to go to Brussels unless thoroughly prepared in every subject, as they have increased the difficulties of the examinations considerably. The examination lasted a fortnight. There were thirteen different professors, who examined separately each candidate in theory and practice in all eighteen subjects, those mentioned above being treated exhaustively.

I am, Sir, yours truly,

May 20th, 1884. A GRADUATE THIS MONTH.

F. H. L.—We do not give medical advice. There are several pay hospitals in existence. Probably the Home Hospitals Association in Fitzroy-square, or Bolingbroke House, Wandsworth Common, might be suitable.

X. Y. Z.—We understand that the questions to which our correspondent refers have not been published.

"THE 'MYSTERIOUS DEATH' AT ILFRACOMBE."

To the Editor of THE LANCET.

SIR,—In your annotation on this case of May 24th I notice a remark as to the absence of information respecting the urine. The full notes of the post-mortem examination contain a memorandum to the effect that the bladder was quite empty, so that no urine was obtainable for analysis. I am, Sir, yours faithfully,

CORNELIUS B. FOX, M.D., F.R.C.P.

Rosemount, Ilfracombe, May 26th, 1884.

MARINE STATION FOR SCIENTIFIC RESEARCH AT GRANTON.

ON the 14th ult. a marine station for scientific research was opened at Granton, near Edinburgh. It is situated at an old submerged quarry on the south shore of the Firth of Forth, about a mile west of Granton Harbour. It possesses three of the most essential requisites for the work which it is proposed to undertake—viz., a small steam vessel fitted for dredging, sounding, and making observations at sea; a floating laboratory, with abundance of sea water, where microscopic work and experiments can be carried on; and an extensive library on marine biology and the physics and chemistry of the ocean, which includes the scientific library of the late Sir C. Wyville Thomson. The island of Inchcolm, on which there is an excellent house, has been rented, and it is hoped that arrangements will be made by which work and experiments may be continuously carried on in this island in connexion with the station. This is the first permanent laboratory established in Britain for the study of marine biology and the sciences connected therewith; but the Marine Biological Association, of which Professor Huxley has undertaken the presidency, contemplates establishing a similar station at Plymouth.

PENDING AMERICAN MEDICAL LEGISLATION FOR TRANS-ATLANTIC STEAMERS.

To the Editor of THE LANCET.

SIR,—It is not long since our attention was directed to many able letters which appeared in the medical papers of this country, written by gentlemen who from practical experience know how the lax sanitary conditions relating to steamers were allowed to lapse, for want of proper supervision, the surgeon being powerless to make suggestions in his own department under the existing rules in many companies. We all know, and thoroughly appreciate, the valuable services rendered by Dr. Irwin previous to his departure from England—how he collected statistics, which must have taken considerable time to prepare, showing how much legislation on this branch of the mercantile marine service is called for. I therefore read with much pleasure in the last issue of your journal that the American House of Representatives have now referred to a Select Committee a Bill which will, if passed, be the means of having all steamers entering their ports constructed with such sanitary improvements as will tend to check the mortality which is known to be so high at sea. During my tenure of office as a surgeon on board an American liner I visited most of the steamers on both sides of the Atlantic, and was invariably impressed with the great want of spacious and well ventilated hospital accommodation, which is so necessary for isolating cases should any infectious disease break out. It will be a great pity if the British Board of Trade allow this all-important subject to pass without notice, especially if the American Government pass a law affecting outward bound ships.

I am, Sir, yours faithfully,

May 20th, 1884. L.R.C.S.I., L.K.Q.C.P.I.

M.B., C.M.—1. THE LANCET of Feb. 25th, 1882, contains a letter by Mr. Higgins, L.R.C.P., certifying surgeon to factories, Bermondsey, in which is mentioned a case heard at the Southwark police-court, where the parents were summoned for neglecting to send their child to school. Illness was pleaded in justification, in proof of which a medical certificate was demanded. On the School Board declining to pay for the certificate, Mr. Bridge dismissed the summons.—2. Captain Perrott, St. John's-gate, Clerkenwell.—3. The Handbook of the Association; Esmarch's Lectures; Weatherly's Lectures.

Liverpool Surgeon has not enclosed his card.

BRINGING THE DEAD TO LIFE.

To the Editor of THE LANCET.

SIR,—Nature is ever opening up to us fresh paths for inquiry and fresh facilities for pursuing them. Mr. W. Arnold Thomson relates in your last issue the means whereby "the machinery of life was set going," in a case where, in his opinion, "the death was real and positive." That Mr. Thomson has really restored a dead body to life appears to be unmistakable, as I gather from his report that a living child, which, by the way, turned out a kicker shortly after birth, was handed to the astonished nurse and grandmother in proof of his startling performance. To deliver a patient safely is at all times attended with a feeling of satisfaction to the medical attendant; but to deliver a woman of a child where death was real and positive, and by "occasional blowing" and sundry other devices to bring that child into life, is surely a sensation reserved for a few favoured mortals, and a fact worth chronicling in history. Were it not that the improbability of the event far outweighs the testimony offered in its favour, were it not that the thing is impossible because opposed to incontrovertible facts, Mr. Thomson might fairly lay claim to divine extraction, as nothing short of superhuman agency has hitherto brought the dead to life.

I am, Sir, yours truly,

South Kensington, S.W., May 20th, 1884. D. MACKINTOSH.

Mr. Chas. P. Gibson.—There can be no doubt that the licentiate named has no such right. The Medical Bill will not alter the present state of the law that a man's titles must square with the nature of his qualification.

Mr. H. B. Fletcher.—We think the cautions already published are sufficient.

A NEW PAVEMENT.

THE *New York Sanitary Engineer* states that a pavement of earthen tile blocks, about eight inches square and four inches thick, impregnated with bituminous products, and laid with hot tar joints on six inches of concrete, has been put down experimentally in Berlin.

Manchester.—The person named does not violate the law. By appending U.S.A. he indicates that he does not hold an English degree. Of course, he cannot recover in a court of law.

"CARPET-BEATING."

To the Editor of THE LANCET.

SIR,—Having read your article in THE LANCET of May 10th, directing public attention to the injurious consequences likely to arise from having carpets beaten in back gardens, &c., we gather from your remarks that you are unaware of the existence of any process for beating carpets except by hand, and we venture respectfully to bring before your notice our system of beating carpets by mechanical means. By our system the carpets are placed in the machine, and the dust drawn away by means of powerful exhaust fans; the dust is then conveyed into underground chambers, where it is acted upon by a jet of steam, and falls in the form of mud. There is no dust sent into the open air. We have now on view in the machinery department of the Health Exhibition one of our carpet-beating machines, and we shall be pleased to give any further explanation to you or others interested in the preservation of health.—We are, Sir, yours faithfully,

SIMMONS & TULLIDGE.

Patent Steam Carpet-beating Works, Station-road, Camberwell, May 24th, 1884.

R. V. P. (Manchester).—In *Lo Spallanzani* for the current month (a well-conducted medical review published simultaneously at Modena and Rome) will be found a paper on Hypertrophy of the Prostate, in which the author transfers from Sir Everard Home to Dr. Valsalnieri the priority of the discovery of the middle lobe of that gland.

Mr. R. Coumbe.—Though it may occasionally happen that a candidate is examined by one of his teachers, means are, as far as practicable, taken to obviate this arrangement.

"A CAUTION."

To the Editor of THE LANCET.

SIR,—In your last two impressions are cautions against an individual who makes it his business to call on medical men. The gentleman in question rang my bell violently a few weeks ago, and on my servant informing him that I was at home he departed hurriedly, after relating identically the same fable about a young lady as that with which he favoured Dr. Tily. But he is only one of many. I have been visited by no less than five sham patients in about as many months, and, fortunately, with no heavier loss than a *borrowed* umbrella. I make it a rule to have all visitors, not personally known to my servant, shown into a small waiting lobby, innocent of any valuables beyond a table, a few chairs, and some illustrated papers, instead of into the ordinary waiting-room. I am satisfied that I have saved many knick-knacks and other portable property by this simple method.

I am, Sir, yours truly,

Orchard-street, W., May 25th, 1884. A. ST. C. BUXTON, F.R.C.S.

A Young Practitioner.—There is no clause to prevent unqualified persons practising so long as they do not pretend to be qualified. The legal offence under the Bill, as at present for the most part, will be the assumption of false titles, leading the public to think they are dealing with a qualified practitioner.

Ignoramus.—The answer to such questions must depend on a variety of details, on which our correspondent should be guided by an experienced and respectable agent or lawyer.

COMMUNICATIONS, LETTERS, &c., have been received from—Mr. Bizer London; Messrs. Christy and Co., London; Dr. J. Thompson Lowne, Edinburgh; Dr. A. Drysdale, Mentone; Dr. Samuel West, London; Mr. Kerchall, Liverpool; Mr. Maycock, Leamington; Mr. Saunders, Camden Town; Messrs. Bell and Sons, London; Dr. Fitzpatrick, London; Mr. Carmady, Camptee; Messrs. Oliver and Boyd, Edinburgh; Mrs. Theobald, Leicester; Messrs. Heal and Sons, London; Mr. Burcombe, Lincoln; Mr. Patrick, Bolton; Dr. Whitla, Belfast; Mr. Browne, China; Dr. Campbell, Carlisle; Mr. Twyford, Hanley; Messrs. Burgess and Co., London; Mr. Thorn, Norwich; Mr. Sutton, Holmes Chapel; Dr. Fothergill, London; Mr. Moulding, Liverpool; Mr. Hoysted, Netley; Dr. Cosgrave, Dublin; Mr. Rachor, Carrolltown, U.S.A.; Dr. Caton, Liverpool; Mr. A. St. Clair Buxton, London; Mr. W. H. Warr, Edinburgh; Mr. Charles Williams, Port Isaac; Mr. Leach, London; Dr. Broadbent, London; Mr. H. Goude, London; Dr. Ward Cousins, Southsea; Surgeon-Major Gray, Bombay; Dr. O'Neill, Lincoln; Dr. Strahan, London; Mr. W. Haward, London; Dr. Wilson, Cheltenham; Dr. Jacob, Leeds; Dr. Robinson, Hull; Mr. A. W. Green, London; Mr. De Gruyther; Dr. Solomon Smith, Halifax; Mr. J. W. Mason, Hull; Surgeon-Major Dobson, Netley; Mr. E. W. White, Canterbury; Mr. Lloyd Roberts, Denbigh; Dr. J. B. Coumbe, Twyford; Miss A. S. Ballin, London; Mr. Butlin, London; Dr. C. B. Fox, Ilfracombe; Messrs. Barnett and Co., London; Mr. P. Swain, Plymouth; Mr. R. Harrison, Liverpool; Mr. Benham, London; Mr. Seymour Haden, London; Dr. Savage, London; Dr. J. H. Morgan, London; Mr. Jefferson, York; Mr. Crosse, Norwich; Mr. J. F. Little, Ben Rhydding; Mr. Warner, London; Dr. Clifton, Cape Colony; Dr. Pearson, Cork; Dr. Bralley, London; Dr. F. A. Haynes, Philadelphia; Mr. W. Ruck, London; Dr. Fenwick, New Boldon; Dr. Shoemaker, Philadelphia; Mr. Pridgin Teale, Leeds; Dr. Tucker Wise, London; Messrs. Simmons and Tullidge, London; Mr. W. Dunstan, London; Dr. West, Bodmin; Mr. Young, Manchester; Dr. Mantle, Stanley; Mr. Walter Whitehead, Manchester; Dr. Sutton, Sittingbourne; Dr. Potter, London; Mr. Armstrong, Manchester; Dr. Hall, Dudley; Miss Bell, Brook Green; Dr. Duncan, London; Mrs. Pratt, Cardiff; Mr. Elliot, Carlisle; Mr. Stilliard; Mr. Deeping, Boxall; Dr. Moriarty, Cork; Dr. Roche, Kingstown; Dr. Ormsby, Dublin; M.B., C.M.; Stand Sure; C. W., Clifton; C. D., Brighton; A. N.; S.; M.D.; Referee; Private Practitioner; Vigilans; A Qualified Undergraduate; E. W.; Puzzled.

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